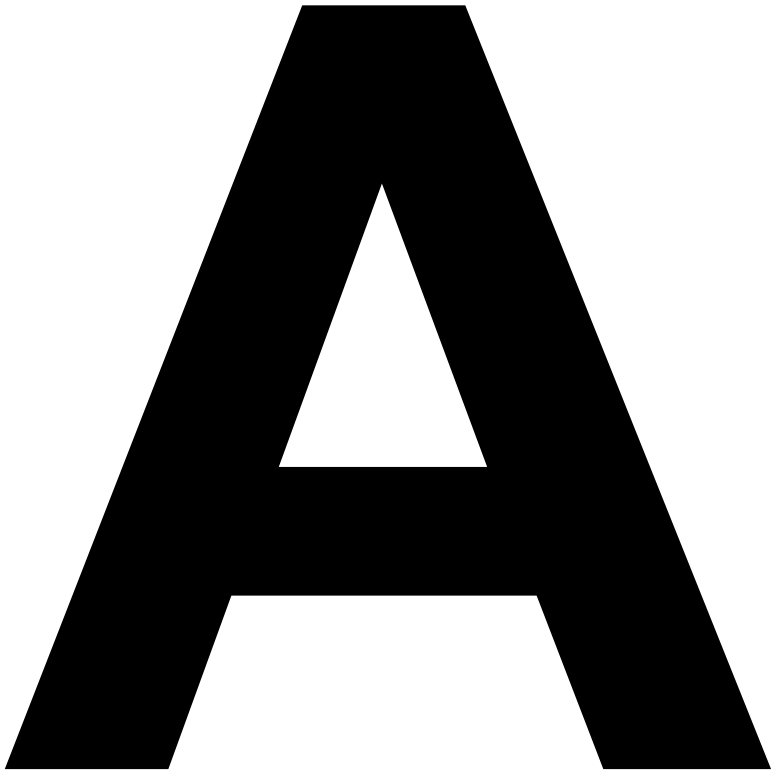
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 9 February 2023**
Meeting no.	**6**	**Time**	**Meeting in public: 9:00am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/1	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/23/2	Apologies for Absence: • Pauline Tagg • Rachna Vyas	To receive	David Sissling	**Verbal**	9:00am
ICB/23/3	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/23/4	Declarations of Interest	To receive	David Sissling	**Verbal**	9:00am
ICB/23/5	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	David Sissling	**Verbal**	9:05am
ICB/23/6	Minutes of the meeting held on 8 December 2023	To approve	David Sissling	**A**	9:15am
ICB/23/7	Matters arising and actions for the meeting held on 8 December 2023	To receive	David Sissling	**B**	
ICB/23/8	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/23/9	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Andy Williams / Richard Mitchell / Angela Hillery	**Verbal**	9:25am
SHARING CASE STUDIES AND PATIENT STORIES					
ICB/23/10	Population Health Management approach to tackle health inequalities in Charnwood	To receive	Dr Bharathy Kumaravel / Dr Leslie Borrill	**C** **presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/23/11	Update on the Development of the LLR ICB 5 Year Joint Forward Plan and Operational Planning 23/24 Submission	To receive	Sarah Prema	**D**	9:50am
ICB/23/12	EMAS Strategy *(Colleagues from EMAS: Will Legge, Director of Strategy and Transformation, Karen Tomlinson, Trust Chair and Suzanna Ashton, Divisional Director for LLR)*	To receive	Will Legge	**E** **presentation**	10:00am
GOVERNANCE DEVELOPMENT					
ICB/23/13	Responding to the Developing Role of the Integrated Care Board	To receive	Andy Williams	**F**	10:15am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/14	Delegation of NHS England functions to ICBs	To approve	Sarah Prema	**G**	10:25am
ICB/23/15	Strategic Leadership Collaborations	To approve	Andy Williams	**H**	10:35am
OPERATIONAL					
ICB/23/16	LLR ICS People and Workforce Report	To receive	Alice McGee	**I**	10:45am
ICB/23/17	Update on performance and delivery	To receive	Yasmin Sidyot	**J**	10:55am
ICB/23/18	LLR System Finance monthly report (month 9)	To receive	Caroline Gregory	**K**	11:10am
ASSURANCE					
ICB/23/19	Assurance report from the Finance Committee	To receive	Cathy Ellis	**L**	11:20am
ICB/23/20	Assurance report from the System Executive Committee	To receive	Andy Williams	**M**	
ICB/23/21	Assurance report from the Quality and Safety Committee	To receive	Caroline Trevithick / Nil Sanganee	**N**	
ICB/23/22	Assurance report from the Audit Committee	To receive	Darren Hickman	**O**	
ICB/23/23	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi	**P**	
ICB/23/24	Report from the inaugural Equality, Diversity and Inclusion Advisory Group	To receive	Alice McGee	**Q**	
ANY OTHER BUSINESS					
ICB/23/25	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:30am

The next meeting of the LLR Integrated Care Board meeting will take place on **Thursday 13 April 2023**, 9:00am to 11:30am, meeting to be held in public via MSTeams.

Where applicable - motion for private session - the Chairman to move, that members of the public be excluded from the remainder of the meeting, owing to the confidential nature of the business to be transacted, which is related to the commercial affairs of the ICB.



Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Held in Public, Thursday 8 December 2022
9:00am – 11:30am, Via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Ms Caroline Gregory	Interim Chief Finance Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Professor Azhar Farooqi	Non-Executive Member, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member, NHS LLR ICB
Ms Pauline Tagg	Non-Executive Member, NHS LLR ICB
Ms Simone Jordan	Non-Executive Member, NHS LLR ICB
Mr Richard Mitchell	Partner Member - acute sector representative (Chief Operating Officer, University Hospitals of Leicester NHS Trust)
Ms Angela Hillery	Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust))
Mr Mike Sandys	Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Dr Nainesh Chotai	Primary Care Sector representative
Professor Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust
Cllr Sam Harvey	Chair, Rutland County Council Health and Wellbeing Board
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board
Mr Richard Henderson	Chief Executive, East Midlands Ambulance Service NHS Trust

In attendance:

Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Affairs Officer, NHS LLR ICB (note taker)
Mr Rob Melling	Mental Health Improvement and Transformation Lead LPT/MH-ICS Team
Ms Katy Green	LLR Community Foundation
Ms Louise Cotton	LLR Community Foundation
Ms Rachel Hall	Falcon Support Services
Mr Michael Simpson	Director of Estates, Facilities & Sustainability (UHL) and SRO
Ms Julie Hogg	Chief Nurse, University Hospitals of Leicester NHS Trust

Five members of the public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/22/71	**Welcome and Introductions** Mr David Sissling welcomed everyone to the meeting of the Leicester, Leicestershire and Rutland Integrated Care Board (ICB). The meeting was held in public and was quorate.	
ICB/22/72	**Apologies for absence from Members and Participants:** • Mr Martin Samuels - Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council)	

ITEM		LEAD RESPONSIBLE
ICB/22/73	**Notification of Any Other Business** There were no additional items of business.	
ICB/22/74	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The register of interests is published on the ICB website and will continue to be reviewed and updated.	
ICB/22/75	**Consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked members of the public for submitting questions in advance of the meeting. <u>Questions received from Sally Ruane</u> 1. *The Chancellor has promised an additional £3.3bn for the NHS for each of the next two financial years. As this is thought to be below what is needed to recover performance and meet cost pressures, do you envisage further cuts and, if so, can these be made without damage to the quality of services?* 2. *Will the ICB be consulting people in Leicester, Leicestershire and Rutland on proposals to close community hospital beds at Feilding Palmer Hospital, Lutterworth and the Rutland Memorial Hospital in Oakham?* In response to the first question, Mr Williams explained that, given the very tough economic situation, the NHS has received a fair settlement, which should provide sufficient funding to enable the NHS to meet its key delivery priorities and cover future inflationary pressures. There will be a continued requirement to make savings – nationally it is noted that this is between 2-3%, in line with prior years. The ICB will continue to adopt an approach to ensure that any efficiencies it is aiming to make do not have a detrimental impact on the quality of services. In response to the second question, Mr Williams advised that there are, currently, no plans to close beds at Rutland Memorial Hospital. Future service provision options at Feilding Palmer and Lutterworth hospitals are being explored. Further work is, however, needed before proposals are finalised. The ICB will ensure that it fulfils the duty placed upon it in statute to involve the public on any proposed changes – either through processes of engagement or by formal consultation. The Health Overview and Scrutiny Committee will play a key role in ensuring statutory duties to engage and consult with the public are fully discharged. Mr Sissling expressed his thanks to members of the public for their questions.	
ICB/22/76	**Minutes of the meeting held on 13 October 2022 (Papers A)** The minutes were approved as an accurate record. It was **RESOLVED** to: • **APPROVE** the minutes.	
ICB/22/77	**Matters Arising and actions for the meeting held on 13 October 2022 (Paper B)** Progress made against specified actions were described in the report., It was agreed that an update on reconfiguration plans will be scheduled for early 2023.	

ITEM		LEAD RESPONSIBLE
	It was noted that the confidential minutes of the meeting held on 14th October would be circulated to members in due course. It was **RESOLVED** to: • **RECEIVE** the action log	
ICB/22/78	**Update from ICB Chair** Mr Sissling expressed his thanks to ICB executive members for providing briefings, updates and assurance reports to the Board members during months where a formal meeting is not held. He also observed that Board meetings agendas are evolving, providing the right balance between strategic, operational and assurance topics with, moreover, the welcome introduction of patient stories and best practice case studies. Mr Sissling had attended the launch of the Voluntary, Community and Social Enterprise (VCSE) Alliance. The alliance would offer greater opportunities for the ICB to work closely with the local voluntary and community sector. An invitation would be extended to the VCSE to present an overview of some of their key work at a future meeting. Mr Sissling advised that a meeting of the Equality and Inclusion Advisory Committee had taken place. Mr Sissling, finally, referred to the independent review into the work of the Integrated Care Systems. The review will be led by Rt Hon. Patricia Hewitt, ICB Chair of Norfolk and Waverley. It will make recommendations to enable the ICSs to have the best prospects to succeed against their four goals. There will be an opportunity for the Board members to make representations and to offer views during the review. **It was RESOLVED to:** • **RECEIVE** the update	
ICB/22/79	**Update from ICB, Acute Sector, Mental Health and Community Sector** Mr Williams drew attention to the LLR Innovation Project Launch celebration event held to acknowledge and celebrate the positive impact made by the scheme. In excess of 100 small investments were made into innovative projects that have made a real difference to the care and experience of many local people. Mr Williams provided an overview of the recent work of the System Executive. This would be covered in more detail in the later agenda item under the assurance section of the Board agenda. Mr Williams advised that interviews for the substantive Chief Finance Officer post will be taking place on 16 December 2022. An update will be provided in due course. Mr Williams invited Executive Director colleagues to provide an update on key issues; Dr. Sanganee on Strep A, Dr. Trevithick on the flu vaccination programme and Ms McGee on the industrial action. Dr. Sanganee explained that appropriate advice is being communicated to parents in relation to Strep A to enable early detection and action.	

ITEM		LEAD RESPONSIBLE
	Dr Trevithick advised that increases in respiratory infections result in pressures on various NHS services and that the flu and COVID-19 vaccination programmes remain the best form of defence, alongside appropriate infection prevention and control arrangements. Ms. McGee stated that the East Midlands Ambulance Service (EMAS) had met the voting threshold to participate in 24-hour strike action on 21 and 28 December 2022. Work is ongoing to understand the potential impact and to ensure appropriate responsive arrangement is in place during this period. Mr Mitchell provided an overview of relevant work and developments at UHL against the four goals of the Integrated Care System. He described ongoing work, often in collaboration with the voluntary sector which would address health inequalities. Mr Mitchel also highlighted some progress in elective care performance but reminded Board members of the very challenging context and the risks associated with the high levels of urgent care demand. Overall occupancy levels throughout the three hospitals were very high and action was being taken in all appropriate areas to optimise patient flow. Mr Mitchell described the outcomes of a Care Quality Commission inspection of the Trust which had particularly focussed on the emergency and medical departments and surgical wards at the Glenfield hospital. Mr Mitchell acknowledged the outcome was somewhat disappointing as the overall rating was "requires improvement". This had not been unexpected however and it was an appropriate reflection of the current position. Ms Hillery emphasised the continuing pressures on acute inpatient capacity, community services and Children and Young Peoples' services. Responsive action is being taken including the opening of additional capacity. This is however causing cost pressures. Ms Hillery was pleased to confirm: the first shadow meeting of the Mental Health Collaborative had taken place. This was a very positive development. Finally, Ms. Hillery drew the Boards attention to the regional recognition of the work being taken forward by LPT in respect of Equality, Diversity and Inclusion.. **It was RESOLVED to:** • **RECEIVE** the updates	
ICB/22/80	**Getting Help in Neighbourhoods (Paper C)** Members welcomed a presentation which highlighted the work of the *Getting Help in Neighbourhoods* scheme. This is a collaborative, multi-agency programme which offers targeted support for individuals facing mental health challenges in the community. Funding was initially awarded to 28 voluntary sector organisations, and this has now been extended to a further 26 organisations. Relevant details were provided about a particularly successful case study - Falcon Homeless and Community Support, which provides accommodation	

ITEM		LEAD RESPONSIBLE
	services to prevent homelessness and to support the homeless. Grant funding enabled the recruitment of two new staff primarily for the provision of 1:1 support and extended group sessions. Examples of individuals who had benefitted from the support were shared. Responding to questions, Mr Melling advised that the various schemes were subject to rigorous evaluation. This has confirmed a positive impact including a deflection of demand away from pressurised core NHS capacity. There is therefore a reduction in the level of urgent mental health presentations. The opportunities to further develop this approach and to capitalise on the emerging networks of voluntary and community sector providers was discussed and supported. Mr Sissling expressed thanks on behalf of the Board and invited a progress update at a future meeting. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/22/81	**Update on the development of the LLR ICB 5 Year Joint Forward Plan (Paper D)** Ms Prema advised that the ICB will be setting out its vision and plan for the next five years within the Five-year Forward Plan for Healthcare. The national requirement is for the Plan is to be produced by March 2023. Key areas to be covered in the plan include addressing health inequity, improving access to services, the use of population health management, integrating care teams at neighbourhood level, supporting the local delivery of services, reforming urgent care and the recovery of elective waiting times. There will be an underlying emphasis on the quality and effectiveness of services. Enabling aspects including finance, people and digital innovation will also be included. Ms. Prema confirmed there will be a range of opportunities for Members to comment on the content of the Plan. A draft will be available in February 2023 to enable engagement- both within the NHS and our wider partnership. Mr Sissling noted the importance of aligning the Plan with the Health and Wellbeing Partnership strategy and those of the Health and Wellbeing Boards as well as the strategies produced by UHL, LPT and Primary Care. Members discussed and welcomed the opportunity to contribute to the plan. A bold and innovative approach was advocated in recognition of the complex challenges which lie ahead. **It was RESOLVED to:** • **RECEIVE and NOTE** an update on the Development of the LLR ICB 5 Year Joint Forward Plan and next steps.	
ICB/22/82	**LLR Health and Wellbeing Partnership Initial Draft for Engagement Integrated Care Strategy (Paper E)** Ms Prema emphasised the draft provided an opportunity for Board Members to comment on the content. This had been developed between representatives of the ICB and Local Government. The draft strategy will be presented to the Health and Wellbeing Partnership on 15 December 2022, and it is anticipated that a final version- which will reflect the outcomes of engagement processes will be approved in mid-2023	

ITEM		LEAD RESPONSIBLE
	Mr Williams observed that this document would be significantly based on the three Health and Wellbeing Board strategies and therefore created an alignment across all the strategies. It was noted that the draft strategy will be subject to engagement and not formal consultation. The process would need to recognize the local elections which will held in 2023 and the associated purdah requirements. Mr Sissling summarised that the strategy had been received as an initial draft with the expectation of further revision in light of the public engagement process. He invited members to support the draft strategy. **It was RESOLVED to:** • **Support** the LLR Health and Wellbeing Partnership Draft Integrated Care Strategy.	
ICB/22/83	**NHS LLR Integrated Care System Green Plan (Paper F)** Mr Simpson introduced the proposed NHS Green Plan and drew the Boards attention to its key elements and the overall objective to make a significant positive impact on the environment.. The Plan sets out action in a number of priority areas including transport, procurement, energy utilisation and medical practice. It focuses on the NHS but has been developed in partnership with key partners including Local Government. It is recognised that the NHS can learn from the successful programmes of work being implemented across both upper and lower tier authorities. Members supported the Plan but suggested some areas where impact could be further enhanced. These included more focus on primary care, better patient appointment arrangements and rationalisation of NHS estates. Subject to these elements being incorporated, Members approved the Plan with an update and progress to be reported to the Board in 4 – 6 months' time. **It was RESOLVED to:** • **APPROVE** the LLR ICS Green Plan 2022-2025 subject to the additional elements as discussed being incorporated.	
ICB/22/84	**Draft Strategy for Primary Care 2022-2025 (Paper G)** An update on the development of the Strategy was provided by Dr.Sanganee. The emphasis will be on achieving a change in the delivery model for primary care with an emphasis on integration, innovative and collaboration with system partners. There will however need to be realism about key constraints including workforce levels. Thie strategy would be expressed at system, place and neighbourhood level. The expectation is that the strategy would include pharmacy, optometry and dental services once commissioning for these services have been devolved to the ICB from NHS England. Members supported the general strategic direction which was proposed, but recognised further work was required and proposed the approval of the Strategy take place in April 2023. **It was RESOLVED to:** • **NOTE** progress to date.	Rachna Vyas / Nil Sanganee

ITEM		LEAD RESPONSIBLE
	• **NOTE** that the development of the strategy will be overseen by the LLR System Executive and LLR Strategic Commissioning Group with the final strategy to be received for sign-off by the LLR ICB in March 2023.	
ICB/22/85	**Ockenden review – progress and update (Paper H)** Dr. Trevithick introduced this item and refenced the comprehensive information which was contained in Paper H. It was recognized that positive progress continues to be made to implement the recommendations from the Ockenden review, the East Kent Inquiry - Kirkup report, and the recommendations from the recent NHS England's Insight visit in June 2022. Full compliance with the recommendations is not anticipated until 2023. A buddying arrangement has been established between the LLR LMNS and Birmingham and Northampton LMNS to enable good practice and learning to be shared. Ms. Julie Hogg acknowledged the ongoing challenges in relation to workforce capacity and explained that the maternity safety plan is to be refreshed. A Care Quality Commission (CQC) visit to maternity services is expected imminently and the outcome will be reported in due course. Following a recent report to the Health Equity Committee, Prof Farooqi requested further information and assurance about three high risk issues: the requirement for continuity of care across the pathway; difficulty in accessing NHS ante-natal classes; and unsatisfactory maternity care for those from BAME communities which is potentially a result of cultural incompetency, lack of training of staff or lack of translation services. Ms. Hogg confirmed that the Ockenden review identified the need for significant investment in the maternity workforce and required the suspension of the midwifery continuity of care model unless safe staffing is in place. She advised that NHS England recently confirmed that focus will be on demonstrating that a plan is in place to re-commence implementation of the continuity of care model rather than meeting a specific target. Ms. Hogg also confirmed that a review of ante- and post-natal care is being undertaken locally. Finally, she advised that within UHL, various workstreams are underway to ensure an appropriate focus on health inequalities, to enable diversity across the workforce and to review relevant capacity and workforce levels. Mr Sissling summarised; it was clear that there was significant executive focus on the key challenges. Progress in key areas was evident but several challenges and risks remained- particularly in relation to workforce. He requested a further update in May / June 2023. **It was RESOLVED to:** • **RECEIVE** for assurance	Caroline Trevithick
ICB/22/86	**LLR System Finance monthly report (month 7) (Paper I)** Ms Gregory introduced the items and summarised the key information contained in Paper I. A year-to-date deficit of £10.9m was reported which represented a £3.1m variance against the system plan. The delivery of cost improvement programmes was generally satisfactory. Ms. Gregory advised that report has been amended to include a system-wide dashboard against targets for all organisations and primary care. She	

ITEM		LEAD RESPONSIBLE
	confirmed that whilst year to date performance was broadly in line with expectations, the prospects for the rest of the year were very challenging. Very significant risks were evident.. Action was being taken within each organisation and across the system to develop mitigations, but the position was particularly difficult considering the urgent care and recovery challenges. Members noted the position and the risks identified. **It was RESOLVED to:** • **RECEIVE and NOTE** the financial position as at month 7 and the forecast performance. • **RECEIVE** for assurance.	
ICB/22/87	**LLR Financial Recovery Plan (Paper J)** Ms Gregory reminded Members that in August 2022 a risk of £88m was reported to the Board with mitigations of £57m, leaving a residual financial risk to break even of £31m. In October 2022, the Board supported the activation of the risk sharing agreement with the respective Boards each approving plans to achieve a break-even position. The report provided an overview of the next steps for the LLR system to determine the 2022/23 outturn position, highlighting the new protocols had been issued by NHS England that must be complied with before any system and/or organisation deviates from its break-even target. Ms. Gregory summarised the considerable work which had taken place to mitigate key risks. However, the prospect of a movement to a year end deficit forecast was becoming more likely. The position would be considered by the Boards of LPT and UHL in December. The System Executive would then review the overall system forecast (incorporating the ICB position) and bring recommendations to the January meeting of the ICB Board. The Board noted the advice that a movement away from a break-even outturn was now very possible and agreed to meet in January to receive relevant recommendations in January 2023 in a private meeting. **It was RESOLVED to:** • **RECEIVE and NOTE** the next steps and timeline to determine the outturn position across LLR for 2022/23.	Caroline Gregory
ICB/22/88	**Medium term financial planning (Paper K)** Ms Gregory introduced the item. The report highlighted the financial challenges faced by LLR over the next five years and indicated the approach the system will need to adopt to progress to a sustainable financial position within this timeframe. The scale of the challenge is significant and will require action beyond traditional cost improvement programmes. This action will be necessary at both an organisational and a system level.. The figures presented in the report will be included in the ICB Five Year Forward Plan and will need to be supplemented with details of the responsive cost containment and transformational. Members discussed the paper and agreed a radical approach will be required with a focus on the opportunities enabled by integrated working. **It was RESOLVED to:**	

ITEM		LEAD RESPONSIBLE
	• **RECEIVE and NOTE** the potential scale of the financial challenge over the forthcoming period and the requirement for effective system working in response.	
ICB/22/89	**Assurance report from the Finance Committee (Paper L)** Ms Ellis introduced the report which highlighted a number of high-risk issues including the in-year financial performance and the medium-term financial prospects.. This had been discussed previously in the meeting and the Board had been briefed on relevant details. The committee would be receiving updates on relevant further mitigating actions. The transformation programmes were rated as high risk considering the variable progress in respect of prioritisation and benefits realisation. Ms Ellis reported that the Committee had formed a generally positive view of the progress being made by UHL in respect of relevant financial matters and the prospects of an exit from the national recovery Support programme. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/22/90	**Assurance report from the Quality and Safety Committee (Paper M)** Ms Tagg advised that no new quality and safety risks have been identified, except for a GP Practice which had been escalated for a rapid quality review in light of locally identified concerns and a CQC report. The Practice has received considerable support but has not yet made the progress required. Further support options are being considered. System Quality Risk within LLR has been rated as red. This reflects the significant residual risks which exist despite the very many mitigating actions which have been implemented. The risks are particularly significant in relation to ambulance handover delays and extended waiting times for urgent care treatment.. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/22/91	**Assurance report from the System Executive Committee and terms of reference (Paper N)** Mr Williams offered an overview of the Committee's work. It has received updates on the development of the 5 Year NHS Delivery Plan and the Health and Wellbeing Partnership strategy. It has also overseen and approved a range of operational developments and investments as set out in the report. Mr Williams explained that the work of the Committee had particularly focussed on the immediate operation challenges including those relating to finance, elective recovery and urgent care. All these carried significant risk with performance not currently being in line with our planned improvement trajectories.. The committee was ensuring further work was taking place to strengthen the relevant plans and was commissioning necessary work from other groups including the Winter Board and the Elective Recovery Board.. Mr Williams invited the Board to consider and approve the updated Terms of Reference for the System Executive Committee and the Strategic Commissioning Group. The Board discussed the report and expressed concern about the lack of evident progress in delivering improvements in some key performance areas.	

ITEM		LEAD RESPONSIBLE
	This was despite the successful implementation of a wide range of initiatives and planned actions. The Board also felt there the presented performance data could be developed further to align it with the key elements of relevant plans and to enable more precise assurance judgements. Mr Sissling said he would work with Mr Williams to take necessary action. The board approved the revised terms of reference. **It was RESOLVED to:** • **RECEIVE** the report. The Board could not, however, be fully assured that current plans and actions would be sufficient to deliver required improvements in key performance areas. The Board also concluded that relevant assurance processes should be reviewed and strengthened. • **APPROVE** System Executive Committee terms of reference (Appendix 1) • **APPROVE** the Strategic Commissioning Group terms of reference (Appendix 3).	
ICB/22/92	**Assurance report from the Audit Committee (Paper O)** Mr Hickman introduced the item and described the main issues covered at the first meeting of the Audit Committee. He explained that work is ongoing to further develop the ICB's Board Assurance Framework. Work to clarify system level risk and risk appetite would be explored further through a Board development session which will take place in January 2023. **It was RESOLVED to:** • **RECEIVE** the report for assurance	
ICB/22/93	**Assurance report from the Health Equity Committee and terms of reference (Paper P)** Professor Farooqi highlighted a positive update received by the Committee of the work underway in UHL to reduce health inequalities. It was noted that a detailed report is to be received from LPT at a future meeting. The Committee had requested that a dashboard be development based on the agreed action plan and the requirements of the Core20Plus5 standard. The committee also expressed a strong view that a Health Equalities Support Unit be established in the near future. This was supported by the Board. The Board was invited to consider and approve the Terms of Reference for the Health Equity Committee. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the Health Equity Committee terms of reference (as at Appendix 1).	
ICB/22/94	**Assurance report from the Remuneration Committee (Paper Q)** The report was received for assurance and noted. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/22/95	**Items of any other business and review of the meeting** There were no further items of business. Whilst reviewing the meeting Mr Sissling observed that there had been a strong focus on a range of strategic matters. The financial position, both in-year and in relation not medium-term prospects had been well covered. The assurance	

ITEM		LEAD RESPONSIBLE
	processes were developing moreover but needed to be strengthened in one or two areas including those that covered operational delivery. The meeting ended at 11:32am.	

Date and Time of next meeting:
The next meeting of the NHS LLR Integrated Care Board will take place on **Thursday 9 February 2023** at 9:00 am via MS Teams. The meeting will be held in public.

B

NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board

Action Log

Key

Completed	On-Track	No progress made

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at February 2023	Status
NHSB/22/85	12 May 2022	LLR Chief Executives' update	Richard Mitchell	To provide an update on reconfiguration plans at a future date.	~~July 2022~~ ~~August/~~ ~~September 2022~~ October / November 2022	Update provided to the Board during January 2023. **ACTION COMPLETE**	**Green**
ICB/22/41	11 August 2022	Primary Care update	Dr Nil Sanganee	Final version of the Primary Care Strategy to be presented for approval in February / March 2022.	~~February /~~ April 2023	As agreed in December 2022, the report to be deferred until April 2023.	**Amber**
ICB/22/83	8 December 2022	NHS LLR Integrated Care System Green Plan	Daljit Bains	An update on this item to be included within the forward planner for 4-6 months' time.	February 2023	**ACTION COMPLETE**	**Green**
ICB/22/85	8 December 2022	Ockenden review – progress and update	Dr Caroline Trevithick	A further update to be provided on this item in April / May 2023.	May 2023	Report on the forward planner for May 2023 meeting.	**Amber**
ICB/22/87	8 December 2022	LLR Financial Recovery Plan	Caroline Gregory	To present an update and recommendations to the Board in a private meeting in January 2023.	January 2023	**ACTION COMPLETE**	**Green**

C

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Population Health Management approach to tackle health inequalities in Charnwood

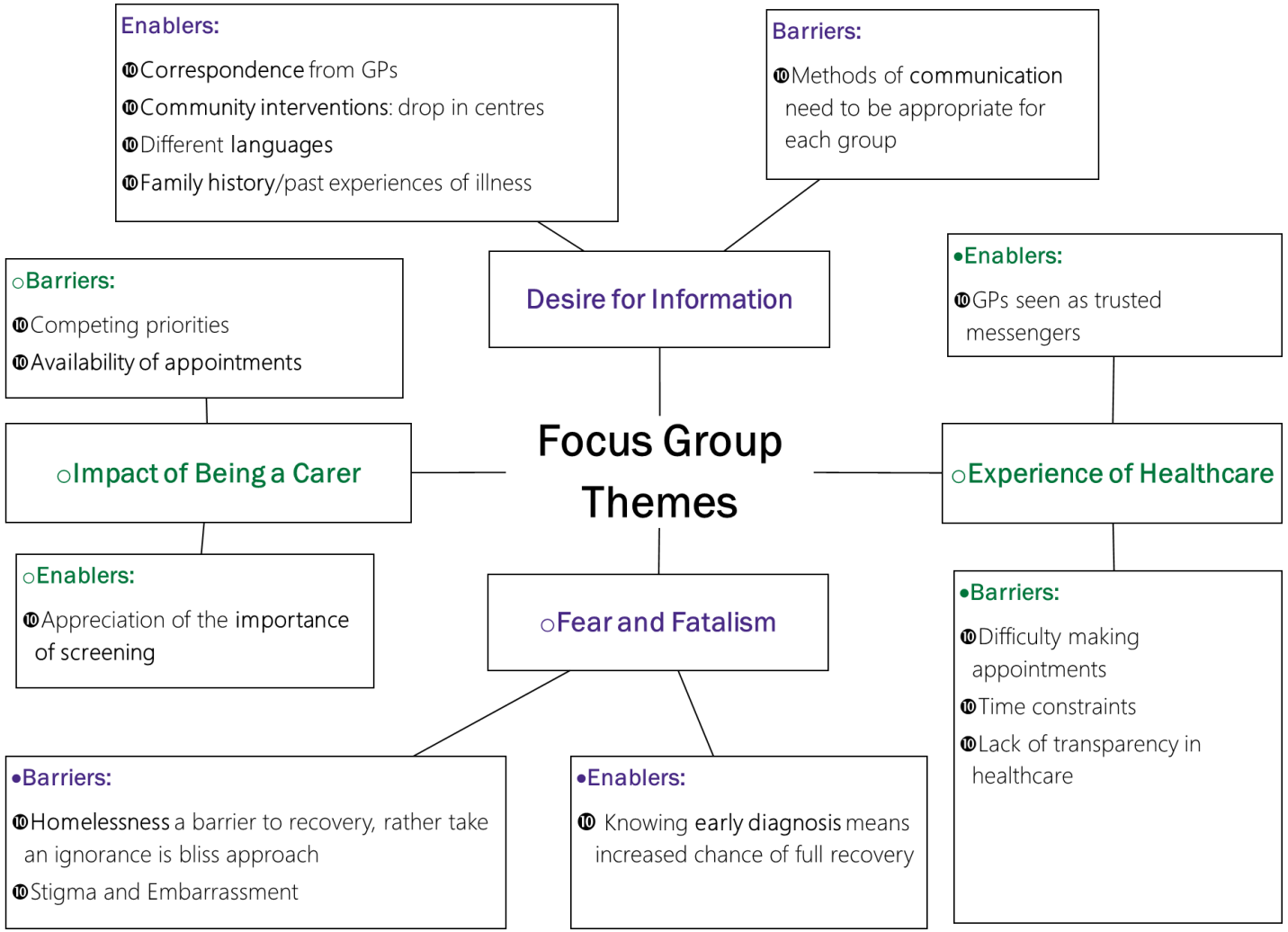
Dr Bharathy Kumaravel, Consultant Public Health (Leicestershire County Council)
Dr Leslie Borrill, Charnwood GP federation

A proud partner in the:
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Background

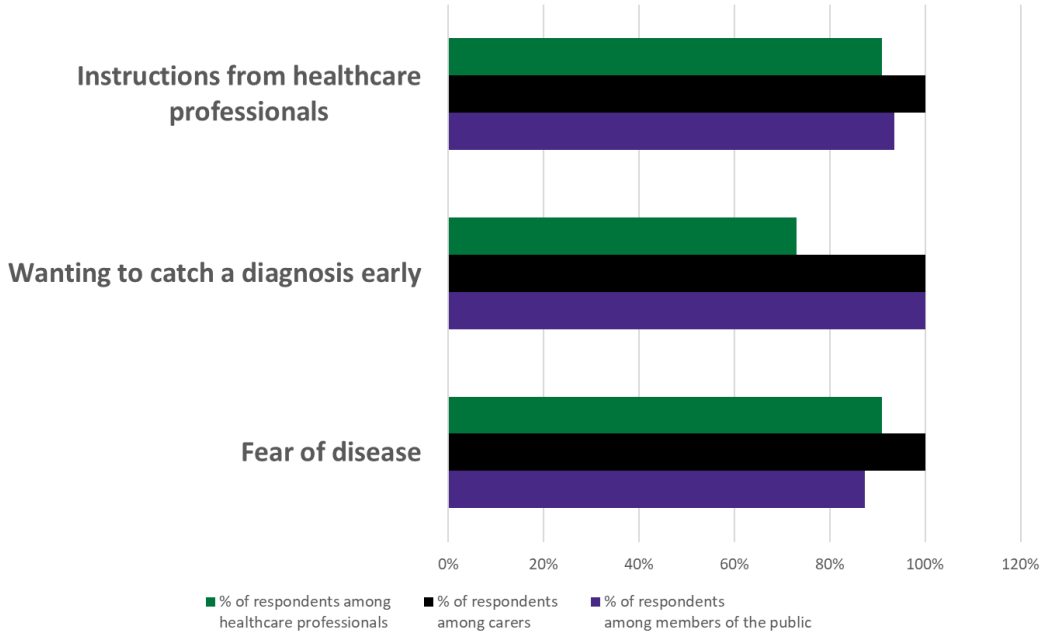
- PCNs were required to produce locality plans highlighting how they were planning to reduce health inequalities within their specified groups, as well as linking to the Core20Plus5.
- The four PCNs (Carillon, Soar Valley, Beacon and Watermead) in Charnwood chose to focus on specific inclusion groups and communities with poor screening uptake as one of their targeted activities.
- Public Health team worked closely with members of the Charnwood Integrated Neighbourhood Team (INT)/Charnwood GP Network to gain a deeper insight into the barriers and enablers to accessing cancer screening services that are faced by certain communities

Focus group themes



Surveys of carers, frontline staff, public

- Enablers relate to patient perception of a disease (such as wanting to catch a condition early and fear of disease) and instruction by the healthcare profession (frequent reminders and direct advice by GP).



Recommendations

- **Recommendation One - Building trust and rapport by:**
  - Working alongside the community to develop **health events** and information.
  - Ensuring **patient participation groups** (PPGs) are representative.
  - Upskilling healthcare staff including GPs, healthcare professionals and receptionists on cultural sensitivity and local language needs.
  - Improving **diagnosis transparency**. Highlighting why a cancer referral has or has not been made.

- **Recommendation Two - Improving access to healthcare by:**
  - Exploring **alternative times (weekends and evening)** for appointments
  - Re-evaluating community provisions such as **mobile clinics** to help establish if the provision is suitably located and accessible.
  - Utilising staff within healthcare that can speak minority languages and **utilising tools to aid translation**.

- **Recommendation Three - Improving knowledge and awareness by:**
  - Adopting a **Making Every Contact Count** (MECC) approach in general and when engaging community champions to target certain groups
  - Actively **engaging the homeless population** to educate on cancer symptoms, screening and being transparent on processes and procedures.
  - Using **trusted sources to share information** within the community. GPs and local health champions were identified as the most trusted sources for health-related information.
  - Further upskilling healthcare staff on NICE Guideline (NG12)
  - Emphasising the importance of prioritising own health, although a better understanding and appreciation is required on other aspects such as respite care

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Enhanced access - cancer screening

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Cancer Screening May 2022 - Jan 2023

Carillon & Beacon PCN – Enhanced Access

Charnwood GP Network CIC

Author(s) Dr Leslie Borrill MBchBBSc MRCGP 4291750 / Kristy Mackinson

Identify patients on behalf of practices and contact the following:

Cervical Screening patients - aged 25 – 64 due or overdue

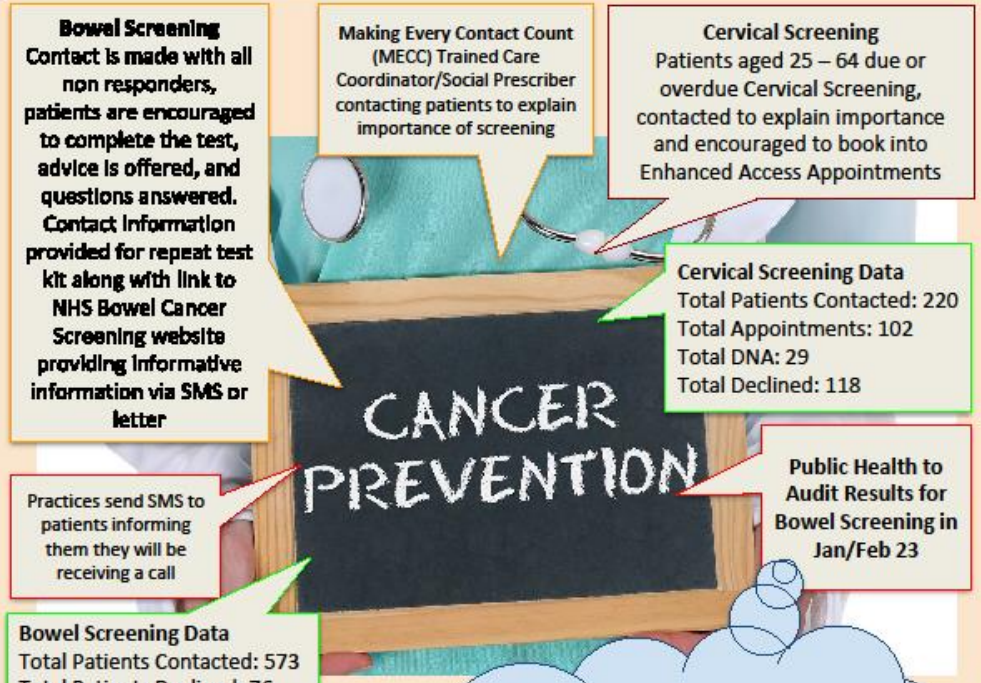
Bowel Screening Non –Responders - Patients aged 60-74 not completed a test in the past 2 years

Aim – to increase uptake in Cancer Screening and improve Early Cancer Diagnosis as part of Cancer DES

Bowel Screening
Contact is made with all non responders, patients are encouraged to complete the test, advice is offered, and questions answered. Contact information provided for repeat test kit along with link to NHS Bowel Cancer Screening website providing informative information via SMS or letter

Making Every Contact Count (MECC) Trained Care Coordinator/Social Prescriber contacting patients to explain importance of screening

Cervical Screening
Patients aged 25 – 64 due or overdue Cervical Screening, contacted to explain importance and encouraged to book into Enhanced Access Appointments



Cervical Screening Data
Total Patients Contacted: 220
Total Appointments: 102
Total DNA: 29
Total Declined: 118

Practices send SMS to patients informing them they will be receiving a call

Public Health to Audit Results for Bowel Screening in Jan/Feb 23

Bowel Screening Data
Total Patients Contacted: 573
Total Patients Declined: 76
No Result following positive contact: 435

Plans for Audit Jan/Feb 23

- Using a sample size of the 436 patients that agreed to complete a test and didn't, what was the reason for them not completing/what would have encouraged them?
- Have we converted patients that have never completed a test before?
- Of the 2 patients that had an abnormal result, did this result in a false positive or have we identified an early onset cancer?

Total Positive Contacts Made: 500
Total Tests Completed: 65
Normal Results Received: 63
Abnormal Result Received: 2

13% of the contacts resulted in a test
12.6% of the tests were normal
2 patients received an abnormal tests

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Bowel Cancer Screening Audit – Beacon and Carillon PCNs

Leicester, Leicestershire and Rutland Integrated Care Board

- A total of 573 eligible patients (aged 60-74) who had not completed a bowel screening test in the proceeding 2 years, were contacted by a care coordinator, in Beacon and Carillon PCN.
- An audit is being planned to explore the outcomes of the telephone call intervention by the healthcare provider.
    - From all the patients who were contacted, review records to explore whether they have completed a bowel cancer screening test to ascertain whether the behaviour change occurred as a result of being contacted by healthcare provider.
    - Where contacted patients went onto have a bowel screening test, to analyse the results of the screening test and any further diagnostic tests- if it resulted in a diagnosis of early onset of bowel cancer.
    - Where contacted patients did not take any further action, a telephone interview will be conducted to understand the reasons for not completing the bowel screening test and what may have encouraged them to do so.
    - For contacted patients, to analyse the data by demographics to identify any health inequalities for both cohorts (those who went on to complete a bowel screening test and for those who chose not to complete a bowel screening test)

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Asthma review extended access

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Asthma Project Evaluation Nov 22 – Jan 23

Carillon Beacon PCN – Enhanced Access

Author(s) Dr Leslie Borrill MBchBBSc MRCGP 4291750 / Kristy Mackinson

Reviewing patients aged 18-65 (working age) who have been using 3+ inhalers in the past 12 months but not received an Asthma review

Aim – To reduce system pressure ahead of winter and increase Asthma care plans on patient's records

Satisfaction with Location of Clinic:

27 - Very Satisfied
15 - Fairly Satisfied
1 - Neither
15 - Not applicable as Tel review

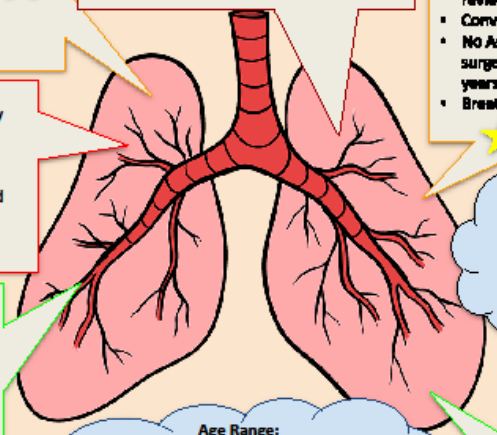
5 x Clinics Held between Nov 22 – Jan 23
84 patient consulted – (45 F2F & 39 Tel)
61 Care Plans created
58 Evaluations completed

Motivation to attend:

- Asthma Review was overdue
- Easier than booking at own surgery
- Phone call prompting Asthma review was due/overdue
- Convenience
- No Asthma Nurse at own surgery, not had review for 3 years
- Breathing issues

58 patients very/fairly satisfied with:

- Staff friendliness
- Appointment time
- Clinic invitation method
- Information provided during appointment



Satisfaction with Service:
48 very satisfied
10 fairly satisfied

Comments on clinic:

- Preferred telephone consultation
- Better parking
- Weekend easier to attend
- Found very helpful
- Fits in well with work/Children
- Easy flowing service
- No wait time
- Prefer at own practice

Ethnic Group:
41 White
13 Asian
3 British/Mixed
1 Chinese

Age Range:
18 - 20 =2
20 - 30 = 9
30 - 40 = 16
40 – 50 = 13
50 – 60 = 10
60 – 65 = 8

Satisfaction with Service:
Found very helpful
Prefers Telephone appt
Good advice from Asthma nurse
Happy to get positive call to book
Pleased with F2F appointment
Happy could come with Son

Gender:
22 Male
36 Female

How likely are you to attend this service again:

- Important to check Asthma
- Much appreciated telephone consultation ++
- Easy to access, appreciated the call to book
- Saturdays work best ++
- Weekends are better due to work
- Weekends better, hard to book at own surgery
- Appreciated money advise from Social Prescriber
- Not aware of Enhanced Access appointments
- Would prefer to go to own surgery as easier, use mobility scooter
- Would return for other clinics if F2F
- Convenient
- Weekends easier due to work
- Saturdays or evenings are better for work as don't need time off work
- Easier to arrange appointment so son could come as well and translate
- Prefer appointments to be outside school hours

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Next steps

- Explore collaboration with UHL respiratory team to enhance the community based respiratory clinic
- Apply lessons learned from the pilot to understanding variation in care in Cardiology
  - Variation in DNA
  - Variation in prescribing Rivaroxaban
- Apply lessons learned to LPT in addressing variation in access to cancer screening and immunisations in patients with LD
- Proactive engagement with communities to raise awareness- Communications and engagement strategy across LLR
- Scale up the systematic approach to population health management across LLR
  - Set up a LLR-wide subgroups with Public Health, Design group and a clinical lead
    - cancer
    - respiratory
    - Cardiology
    - Childhood Immunisation

Questions?

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**9 February 2023**	**Paper:**	**D**
Report title:	**Update on the Development of the LLR ICB 5 Year Joint Forward Plan and Operational Planning 23/24 Submission**		
Presented by:	Sarah Prema, Chief Strategy Officer, LLR ICB		
Report author:	Ket Chudasama, Deputy Chief Strategy and Planning Officer, LLR ICB Amit Sammi, Head of Strategy and Planning, LLR ICB		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer, LLR ICB		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** an update on the development of the Leicester, Leicestershire and Rutland Integrated Care Board 5 Year Joint Forward Plan and Operational Planning 2023/24 Submission.

Purpose and summary of the report:

1) This report provides the NHS LLR Integrated Care Board with a summary of the progress to date and next steps to the develop the LLR ICB 5 Year Joint Forward Plan (JFP) and Operational Planning 2023/24 submission.

2) Official NHSE guidance on developing the JFP was released alongside 2023/24 Priorities and Operational Planning guidance on the 23 December 2022.

3) The NHS LLR Integrated Care Board and our partner NHS Trusts have a legal duty to produce the first JFP for healthcare by 1 April 2023, followed by a period of engagement and refinement with a final plan produced and published by the 30 June 2023.

4) The JFP complements the production of the Integrated Care Strategy, led by the LLR Health and Wellbeing Partnership; the JFP is expected to set out steps for delivering the integrated care strategy.

5) A project group has been established to drive forward development of the plan, with regular updates to the Executive Management Team, System Executive and the Integrated Care Board.

6) The 2023/24 Operational Planning guidance outlines the three key national priorities: recovering core services and improving productivity, making progress on our key NHS Long Term Plan ambitions and transforming the NHS for the future.

7) A smaller, more focussed list of 31 national objectives have been set and are aligned to the three key national priorities. The guidance also sets out a list of evidence-based actions that will help deliver the national objectives and systems are asked to develop plans to implement these.

8) The Operational Plan will be submitted in draft form on 23 February 2023 and a final submission to be made by 30 March 2023.

9) A weekly System Planning Operational Group is in place to oversee the co-ordination and production of all aspects of the plan, with regular updates and steer from the System Executive and the Integrated Care Board.

Appendices:	N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Input and steer have been sought at the following meetings to support development of the plan: • EMT – ODG development session 3 October 2022, 28 November 2022 • Clinical Executive 13th October 2022 • ICB Board 10 November 2022, 12 January 2023 • System Executive 11 November 2022, 9 December 2022, 23 December 2023, 13 January 2023

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not in the context of this paper
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not in the context of this paper
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper. However, it does include a timeline for engagement with wider stakeholders including patients and the public for JFP
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not at this stage. However, an overarching equality impact and risk assessment will be undertaken as the plan is further developed.

Update on the development of the LLR ICB 5 Year Joint Forward Plan and

2023/24 Operational Plan

9 February 2023

Introduction and Background

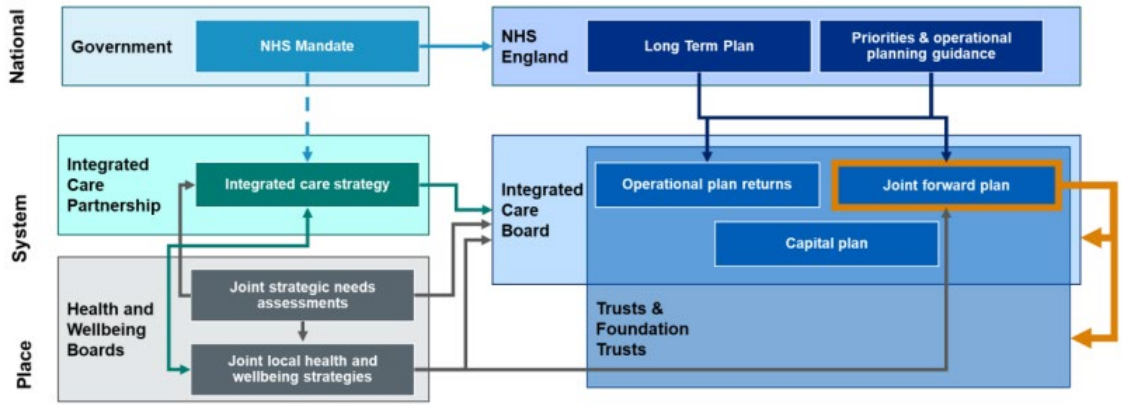
1. The NHS LLR Integrated Care Board and our partner NHS Trusts have a legal duty to produce the first 5-year joint forward plan for healthcare by 1 April 2023, followed by a period of engagement and refinement, with a final plan produced and published by the 30th June 2023.

2. Official NHSE guidance on developing the joint forward plan (JFP) was published alongside 2023/24 priorities and operational planning guidance on the 23 December 2022. The JFP guidance permits significant flexibility to determine scope, structure and development but must pay due regard to the following three principles**:**

    - Fully aligned with the wider system partnership's ambitions;
    - Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments';
    - Delivery focused, including specific objectives, trajectories and milestones.

3. The JFP complements the production of the Integrated Care Strategy, led by the LLR Health and Wellbeing Partnership; the JFP is expected to set out steps for delivering the integrated care strategy. The relationship of the JFP with other strategies and plans is shown in figure 1 below:

Figure 1: Relationship of the JFP with other strategies and plans[11]



4. The JFP must include a statement of final opinion from each of our three local Health and Wellbeing Boards providing endorsement. ICBs and their partner trusts should expect to be held to account for delivery.

Progress to date

5. The development of the JFP has been guided by discussions and workshops with System Executive and the Integrated Care Board. The emerging consensus for the JFP is to focus upon:

- adopting a population health management approach;
- addressing the urgent system pressures such as availability of GP appointments, reducing ambulance handover delays and reducing the elective backlog of patients waiting for treatment;
- cost-effectiveness and optimising the use of our resources;
- supporting evidence-based interventions;
- supporting prevention and self-care;
- alignment with the emerging LLR clinical model;
- the key areas of transformation rather than all services we are responsible for commissioning; resulting in a plan that is expected to be a 50 page document;
- the 'golden thread' of health equity throughout the document;
- producing an ambitious plan but acknowledging where improvements may be in longer term;
- the key transformational areas of focus:
    - Mental Health, Learning Disabilities and Autism & Dementia
    - Right Place, Right Time, Right Service
    - Management of Long Term Conditions, frailty & multimorbidity
    - Integrated health and social care teams (Hubs)
    - Women's health
    - Prevention
    - Optimal pathways for elective care
    - Children and Young People.

6. The intention is to, where possible, underpin the plan by modelling the impact of population health management, integrated health & social care teams and right place, right time, right service across activity, workforce, performance, outcomes, finance, digital and health economics.

7. A project group has been established to drive forward development of the plan. Weekly updates are provided to EMT with regular touch points and steer from System Executive and the Integrated Care Board.

Next steps

8. An indicative timeline of next steps is detailed in the table 1 below:

Table 1- Indicative timeline for next steps, engagement and approval

JFP Key Milestones	Where	Date
Initial draft of JFP development	System strategy and planning team	3 February 2023 to end of February 2023
Progress update	ICB Board	9 February 2023
Progress update	System Executive	10 February 2023
Update on key transformational areas of focus	Leicestershire Health and Wellbeing Board	23rd Feb 2023
Draft JFP for comment	ICB Board	23rd March 2023
Draft JFP for comment	UHL Trust Board	9th March 2023
Draft JFP for comment	LPT Trust Board	Feb/March 2023 (Date TBC)
Update on key transformational areas of focus	Leicester City Health and Wellbeing Board	16th March 2023

Update on key transformational areas of focus	Rutland Health and Wellbeing Board	21st March 2023
Monthly updates to NHSE	System strategy and planning team	Jan – June 2023
Share Draft with ICB Board	ICB Board	Early March 2023
Draft submission for feedback	NHSE	30th March 2023
Further engagement with partners on the JFP	• LLR Health and Wellbeing Partnership (date/s TBC) • Health and Wellbeing Boards - Final opinions • Patients and the public • System partners, Trust Boards etc	March – June 2023 – need to take into account pre -election period (last week in March to 4th May 2023)
Ongoing refinement and development of plan	System strategy and planning team	Feb – June 2023
Sharing development of plan	System Executive	24th Feb; 10th March
Submission of final plan for approval	ICB Board	8th June 2023
Any final changes following ICB	System strategy and planning team	8th June – 29th June 2023
Submission to NHSE	System strategy and planning team	30th June 2023

LLR 2023/24 Operational Plan

9. The 2023/24 priorities and operational planning guidance was published on 23 Deecember 2023. The guidance reconfirms three key national priorities for 2023/24:

    - Recover core services and improve productivity;
    - Make progress in delivering the key NHS Long Term Plan ambitions and
    - Continuing to transform the NHS for the future.

10. A smaller, more focussed list of 31 national objectives (appendix one) have been set and are aligned to the three key national priorities. This includes hospital trusts to see 76 per cent of accident and emergency patients within four hours, improving category 2 ambulance response times to an average of 30 minutes, and eliminating waits over 65 weeks for elective care by March 2024, except for where patients choose to wait longer or in specific specialties.

11. The guidance also sets out a list of evidence-based actions that will help deliver the national objectives and systems are asked to develop plans to implement these.

12. NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations (including COVID-19 and Elective Recovery Funding) are flat in real terms with additional funding available to expand capacity.

13. To deliver a balanced net system financial position for 2023/24 and achieve our core service recovery objectives, we must develop robust plans that deliver the 2.2% efficiency target and improve levels of productivity eg reduce agency spending to 3.7% of the total pay bill in 2023/24.

14. The strategic challenge for the system will be how our plans can 'balance': achieving key performance standards, improving productivity, delivering a break-even financial plan and make progress on our JFP ambitions.

Progress to date

15. The development of the Operational Plan has been informed by discussions with the System Executive and progressed by the weekly System Planning Operational Group (SPOG). The key updates are:

- Setting activity levels
    - Reviewing draft % activity levels (set by national team) against our 1st cut activity plan;
    - Developing activity level options for recommendation to System Executive on 10 February 2023;
- Finance
    - Draft financial plans received from organisations on 25 January 2023, to be summarised and explained for discussion with Chief Finance Officers on 1 February 2023 and System Executive on 10 February 2023;
- Workforce
    - High level workforce numbers and narrative across all providers to be shared by 27 Jan 2023;
- Business cases and prioritisation
    - Received business cases focussing upon efficiency, delivering key priorities and quality improvements from all partners on 13 January 2023;
    - Applying pass/fail criteria against all business cases received;
    - Establishing a system-wide Prioritisation Group to score and rank the remaining business cases. This will be presented to the Clinical Executive and Transformation Assurance Group (for moderation) and System Executive / ICB Board for final decision-making;
- Narrative content
    - Planning packs have been distributed to Design Groups / Collaboratives in early Jan for submission by 27 Jan 2023. These packs outline the key actions required from the guidance and our plan to deliver them.

Next steps

16. A timeline of next steps is detailed in the table below:

Table 2- Indicative timeline for next steps and approval

Operational Plan Key Milestones	Where	Date
Draft narrative and trajectories received from leads	System planning team	27 January 2023
Operational planning update	ICB Board	9 February 2023
Draft trajectories (activity, workforce & performance) Draft narrative headlines Draft financial plan	System Executive	10 February 2023

Draft submission (trajectories / narrative) following 10 February 2023 System Executive or ICB CEO sign off	NHSE	23 February 2023
Draft submission (trajectories / narrative) for comment	ICB Board	9 March 2023
Final trajectories (activity, workforce & performance) Final narrative Final financial plan	System Executive	10 March 2023
LPT Executive Management Board and Trust Board		17 March 2023 28 March 2023
UHL Executive Management Board and Trust Board		14 March 2023 6 April 2023
Final submission (trajectories / narrative) for approval	ICB Board (Extraordinary)	23 Mar 2023
Final submission (all trajectories / narrative) following ICB Board sign off	NHSE	By 30 March 2023

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

RECEIVE and NOTE

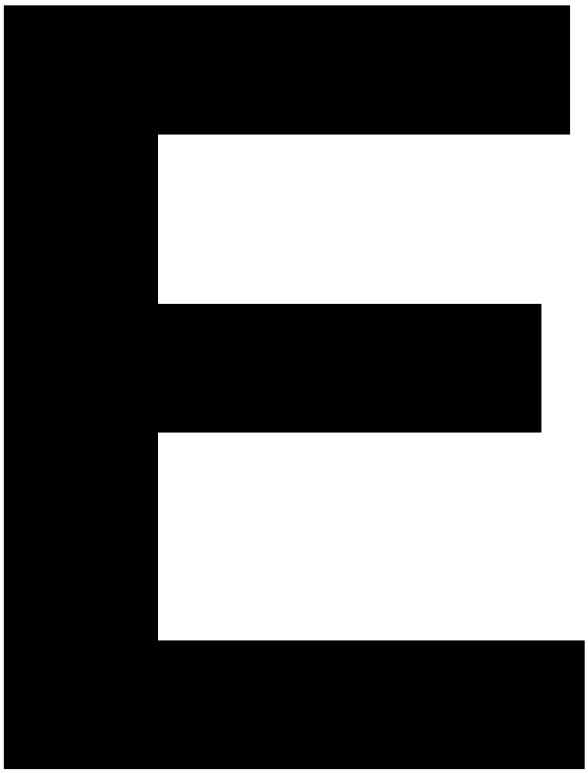
- the update on the development of the LLR ICB 5 Year Joint Forward Plan and next steps
- the update on the development of the 2023/24 Operational Plan and next steps

Appendix One

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*



East Midlands Ambulance Service NHS Trust

EMAS Strategy development

Respond – Develop - Collaborate

Why a new strategy now?

- ICB/ ICP landscape
- Provider collaboratives
- Post covid – changing landscape and system pressures. NHSE Next Steps and Going Further faster in winter, drive a different approach
- Ensure our model responds to the direction for proactive approach and keeping more people at home.
- Emerging Urgent care strategy- developing both corporate and clinical strategies

ICB Commissioning of Ambulance services guidance (NHSE Aug22)

- “With clear commissioning arrangements agreed and in place, ambulance services can best leverage their unique position and knowledge of the community and UEC system, taking a leading role in the delivery, improvement, and transformation of out of hospital services and integrated urgent care across ICSs - in support of the four core purposes of the ICS”

- “working through these opportunities and challenges in the spirit of co-design, co-production, and collaboration across the system”

National Urgent and emergency care strategy in development

"ED/ ambulance is an active choice for patients, not the default"

- Role of ambulance sector
  - Interface with primary care and community services (cat 3/ 4)
  - Skilled as extension of intensive care
- Role of paramedics- primary care , acutes, rotational opportunities
- Technology/ digital- Video consultation & diagnostics on scene
- Potential targets to increase see & treat, hear & treat
- Tackling health inequalities- tailored approach with most deprived communities
- Multi-disciplinary workforce- focus on patient needs not sector/ organisation
- Greater integration between 999 and 111

Principles of strategy development

- We want to be an integrated urgent provider in collaboration
  - provide both cat 1/ cat 2 and cat3/4 urgent care, but not one at the detriment of the other. Need to change our delivery model to do both
  - Provide patient transport services
- We can contribute to health inequalities agenda
- Working with systems to realise our vision for workforce
- Single strategy aligned to system strategies with the ability to flex to respond to different ICSs and different local patient needs
- Developed in collaboration with our people, systems and patients
- Informed by national strategic direction and local ICP strategies

Developing our strategy

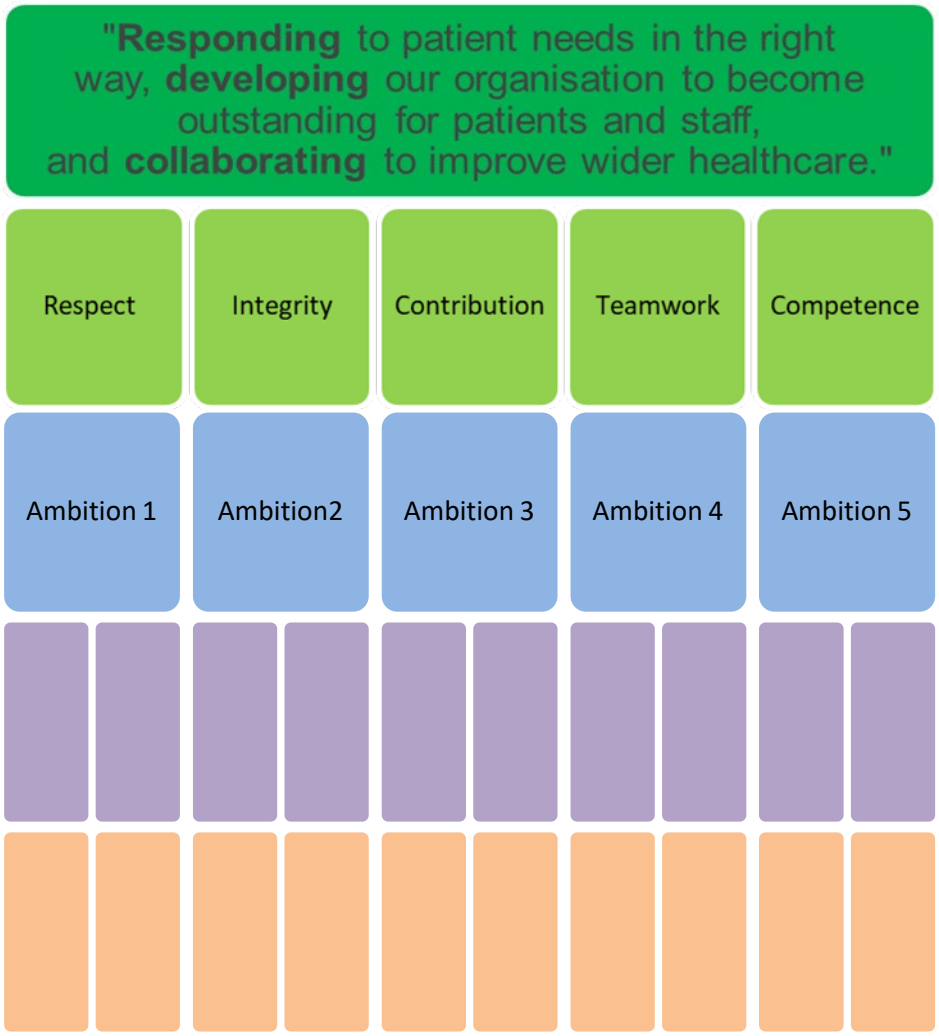
Vision

Values

Ambition

Actions/ Objectives

Outcomes



DRAFT Ambitions statements

We will deliver outstanding patient care by developing new, innovative clinical practices and by working in collaboration with our partners and the public.

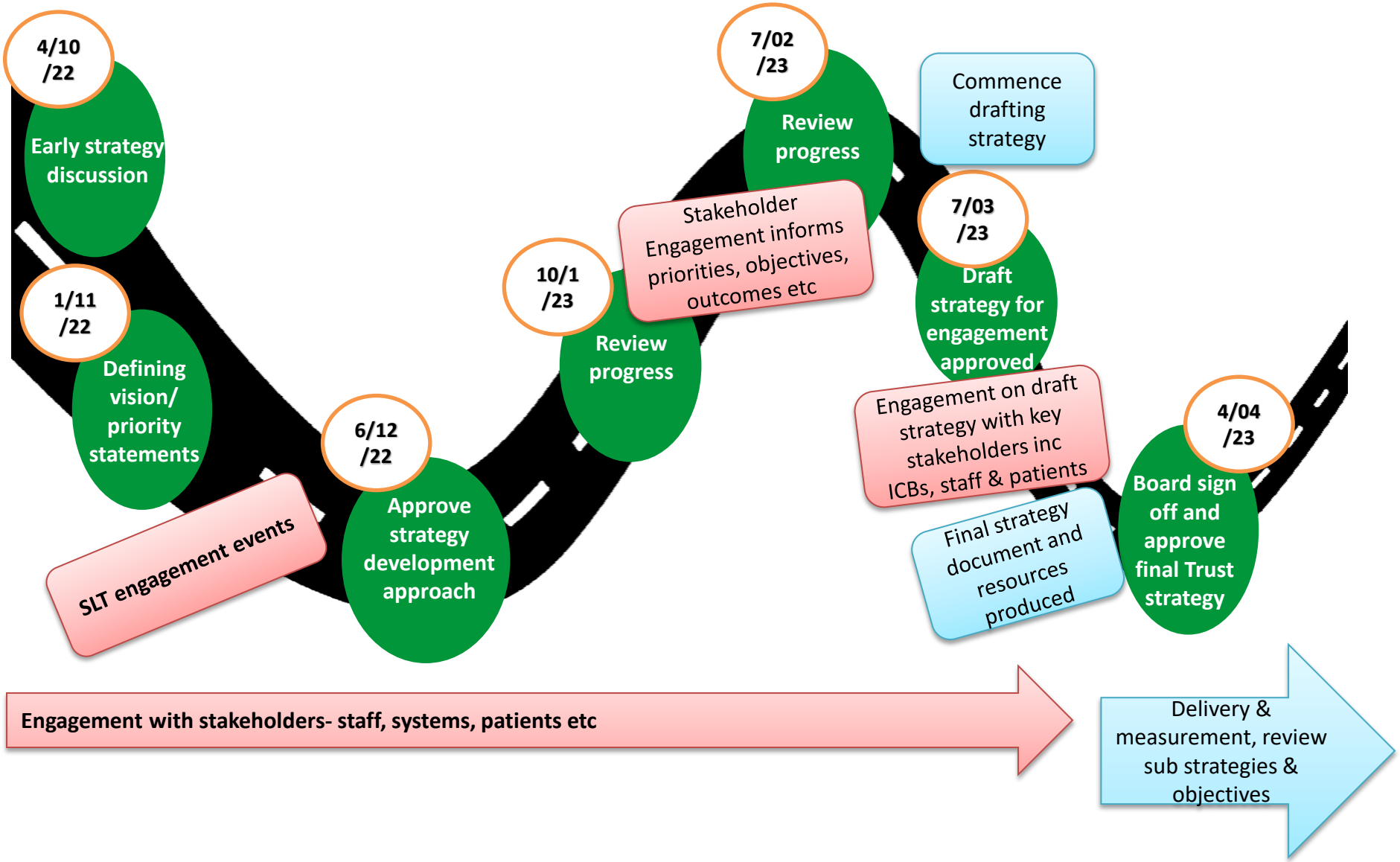
We will be an attractive employer of choice, developing and retaining highly skilled, engaged and diverse people reflective of our local communities.

We will deliver improved outcomes for our patients through the most appropriate equipment, technology, vehicles and facilities

We will deliver safe, effective, compassionate care for patients, embedding a culture of compassion, continuous improvement and productivity.

We will work in partnership to reduce health inequalities and improve the health of our population, whilst ensuring sustainability.

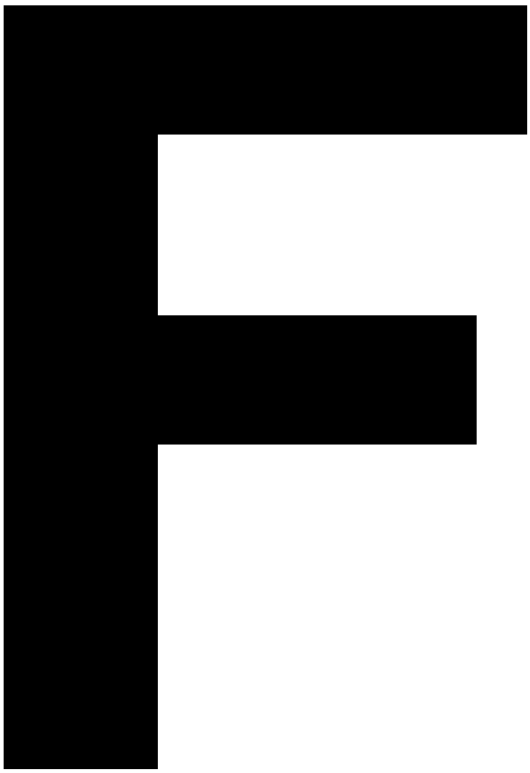
Strategy development and engagement timeline



Respond – Develop - Collaborate

Discussion

- Do our strategic ambitions seem right, are they aligned with system thinking?
- How can we work with the system to deliver these ambitions? What would you like to see us do?
- How can we engage further with the system to develop the detail of our strategic ambitions as well as our clinical strategy?



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	9 February 2023	**Paper:**	**F**
Report title:	**Responding to the Developing Role of the Integrated Care Board**		
Presented by:	Andy Williams, Chief Executive LLR ICB		
Report author:	Andy Williams, Chief Executive LLR ICB		
Sponsor:	Andy Williams, Chief Executive LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

This report aims to describe the evolving role of the LLR Integrated Care Board and provides the context for proposed changes in governance and management arrangements that the Board will be asked to consider.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The focus is on mitigating strategic risks aligned to the BAF.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however due regard is considered when considering the detailed strategies and policies.

Responding to the Developing Role of the Integrated Care Board

Introduction

1. This report aims to describe the evolving role of the LLR Integrated Care Board and provides the context for proposed changes in governance and management arrangements that the Board will be asked to consider.

Background

Devolution

2. Even though the Integrated Care Board is only in its first year of operation its role and remit continues to evolve. From April 2023 it will assume responsibility for commissioning Pharmacy, Optometry and Dental primary care services and from April 2024 it will assume responsibility for commissioning a substantial proportion of the specialised services currently commissioned by NHS England. In addition to this, it will assume increasing responsibility for a range of functions currently delivered by NHS England as the new operating framework for NHS England is introduced. These functions will include an increasing leadership role in respect of specialised networks such as the cancer network and a greater role in performance assurance and improvement.

3. NHS England is currently devolving functions to Integrated Care Boards and adopting its new operating model as part of wide-ranging reforms that will see its operating costs at a regional level reduce by around 40%. Guidance is expected imminently that will ask Integrated Care Boards to introduce further reductions in their operating costs including in those areas devolved to them by NHS England.

4. The Integrated Care Boards in the Midlands region have been working together with NHS England to plan and implement these changes. This collaboration has been at a whole region level for some services and on an East and West Midlands basis for others. The five East Midlands Integrated Care Boards have in addition, identified several opportunities for collaboration that could enhance service delivery.

Further Opportunities

5. Within the East Midlands there are already examples of working across Integrated Care Boards. There are existing arrangements for commissioning ambulance and NHS 111 services, provider collaboration in the delivery of mental health services, clinical and managerial networks and mutual aid arrangements for key delivery areas such as elective recovery. There are also examples of collaboration in sharing expertise and shared learning.

6. All five Integrated Care Boards have relationships with the two local Commissioning Support Units and in many cases these agreements need to be renewed. This may present opportunities for improved service coordination and cost reduction.

7. Several of the Boards are looking to review their respective key commissioning policies and, since there are considerable cross boundary flows between systems, there may be merit in co-ordinating this work to reduce postcode variation in service access.

8. Several key partners have East Midlands footprints and there may be merit in establishing relationships with these groups at this level. Examples would include the Academic Health Science Network, Local Government (who have a process for collaboration at the East Midlands level) and some clinical networks.

9. To take advantage of these opportunities and others, the five Integrated Care Boards in the East Midlands have been exploring a more formal basis for joint working.

A Positive Response

10. In response to these challenges and opportunities, the Integrated Care Board in Leicester, Leicestershire and Rutland will receive proposals detailing:
    - the governance arrangements for devolved functions,
    - the establishment of a joint committee with the other four East Midlands Integrated Care Boards to support this and other areas of partnership working,
    - proposals for the sharing of management roles and costs across Integrated Care Boards.

11. The intention through this is to ensure that the Integrated Care Board for Leicester, Leicestershire and Rutland can continue to operate as an independent statutory body within a system partnership whilst at the same time achieving the benefits of collaboration at scale through partnership working with other systems where appropriate.

Conclusion

12. The establishment of the Integrated Care Board in Leicester, Leicestershire and Rutland has only recently taken place, but already it is clear that there are both challenges and opportunities that can best be addressed through collaboration with other systems. In response, proposals for collaboration will be brought through to the Board to ensure that the Board is able to continue to deliver effectively for the population it serves.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**9 February 2023**	**Paper:**	**G**
Report title:	Delegation of NHS England functions to ICBs		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Sarah Prema, Chief Strategy Officer Jo Grizzell, Senior Planning Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer		

To approve ☒	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **APPROVE** the workforce hosting arrangements.
- **APPROVE** the Distributed Leadership arrangements.
- **APPROVE** delegated authority to the Chair and Chief Executive to consider and approve the Tier 1 governance arrangements including the Joint Working Agreement, Joint Committee Terms of Reference and Scheme of Reservation and Delegation.
- **APPROVE** delegated authority to the Chair, Chief Executive and Audit Committee Chair to approve any changes necessary to the LLR ICB governance arrangements to reflect delegation to the Joint Committee.

Purpose and summary of the report:

The purpose of this report is to provide the LLR Integrated Care Board with the current position in relation to the delegation of PODs (and in preparation for specialised commissioning) services from NHS England with effect from 1 April 2023.

The direction of travel has been agreed by the Chief Executives of the five East Midlands ICBs at their monthly timeout sessions. In addition, a number of working groups have been established to develop the underpinning documentation ie governance, finance, complaints etc.

Appendices:	Not applicable
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Not applicable

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	

		☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Risks have been identified associated with the programme and have previously been shared with members. These have not been escalated to the Board Assurance Framework at this stage.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None identified at this stage.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	NHS England has confirmed that they will be undertaking communications with patients and the public to ensure that they are aware of the changes with effect from 1 April 2023.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was,	NHS England has undertaken an equality impact assessment to ensure that there will not be a negative impact following the delegation of services.

provide which page / paragraph this is outlined in within the report.	

Delegation of NHS England Functions to ICBs

Background

1. This paper sets out an overview of the Delegation of NHS England (NHSE) functions to ICBs and requests delegated approval of the governance arrangements.

2. By delegating some of NHS England commissioning functions to ICBs the aim is to break down barriers and join up fragmentated pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it. The services that will be delegated to ICBs are:
    - Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1 April 2023
    - Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1 April 2023
    - Specified Specialised Services (Acute & Pharmacy) on 1 April 2024

3. For LLR the following contracts will be delegated from 1st April 2023:

Sector	Value of Contracts £m	Number of Contracts
Secondary Care Dental	7.8	2
Primary Dental	41.9	147
Community Dental	3.1	1
Ophthalmic	12.1	170
Pharmacy	21.6	227
Other	0.9	
Total	**87.4**	**548**

4. Delegation of these services is a national policy. In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. The ICB will be responsible for any claims (negligence, fraud, recklessness, or breach of the Delegation). However, in all cases NHS England remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.

5. ICBs across the Midlands and the NHSE team have been working together to co-produce our approach. This work has been progressed through existing regional collaborative forums and for ICBs has been led at the Chair and Chief Executive Officer (CEO) level.

6. This paper sets out the proposed "hosting" arrangements and the proposed governance arrangements for the future of delegated services.

Hosting Arrangements and Distributed Leadership Model

7. The planning footprints of the East Midlands, West Midlands (for PODs and where agreed other East Midland wide services) and Midlands (for Specialised Services and where agreed other Midlands wide) have been identified as being the basis for multi-ICB planning and decision-making.

8. In addition, the ICB Chief Executives and NHSE Executives have worked on the principle that skills are retained and that specialised resources for delegated services are shared between ICBs and between ICBs and NHSE, where appropriate.

9. All decisions will be through formal joint committees ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another.

10. However, the hosting of the workforce will require one ICB to provide this function on behalf of the other ICBs (and, for specialised services, NHSE). The Host ICB will provide, oversight, leadership, and support for the workforce. The workforce will work for and on behalf of, each ICB within the planning footprint (East/West or Midlands). This will be supported by a formal hosting agreement between the ICBs and, for specialised services, between the ICBs and NHSE.

11. The Host will not make commissioning decisions on behalf of other ICBs or NHSE; all decisions will be made through the Joint Committees and their sub-groups. The Primary Care Pharmacy, Optometry and Dentistry workforce will be hosted on an East and a West Midlands footprint. The host ICBs have been approved by the ICB CEOs as follows:
    - East Midlands - Nottingham & Nottinghamshire ICB
    - West Midlands – Birmingham & Solihull ICB

12. The complaints workforce that aligns to Primary Care will also transfer to the Hosts outlined above. However, there is recognition that there are still some national policy agreements and operating model challenges to be resolved, informed by national policy discussions.

13. Services will be delegated from 1 April 2023. However, it is planned that, subject to consultation, workforce transfers for POD, primary medical service support and complaints staffs will transfer on 1 July 2023. This will be on a multi-disciplinary basis, also including commissioning finance and clinical reviewers but with specialised healthcare public health team members aligned or embedded to teams, not transferred.

14. The Specialised Services joint ICB and NHS England workforce will be hosted by one Midlands ICB on behalf of all eleven ICBs and NHSE. This will be Birmingham & Solihull ICB for the Midlands region and will be supported by a formal hosting agreement between the ICBs and NHSE – to developed later in 2023.

15. Recognising that authority does not rest with one individual or individual ICB a model of Distributed Leadership will be adopted to ensure the delegation is effective and all ICB's share the responsibility.

16. As part of our collaborative approach the East Midlands ICB Chairs and CEOs have agreed the following distributed leadership model that will see the identified ICB leading on the aligned subject matter on behalf of the other ICBs:
    - Northamptonshire – Collaborative governance and Commissioning Support Unit arrangements
    - Leicestershire – Specialised Commissioning (linking with Birmingham & Solihull ICB as combined East and West lead)
    - Nottinghamshire – PODs

- Derbyshire – Ambulance Services and NHS 111
- Lincolnshire – Broader collaboration with Local Authority, networks and policy.

Governance Arrangements

17. Figure 1 below sets out in diagrammatical form the proposed governance structure.

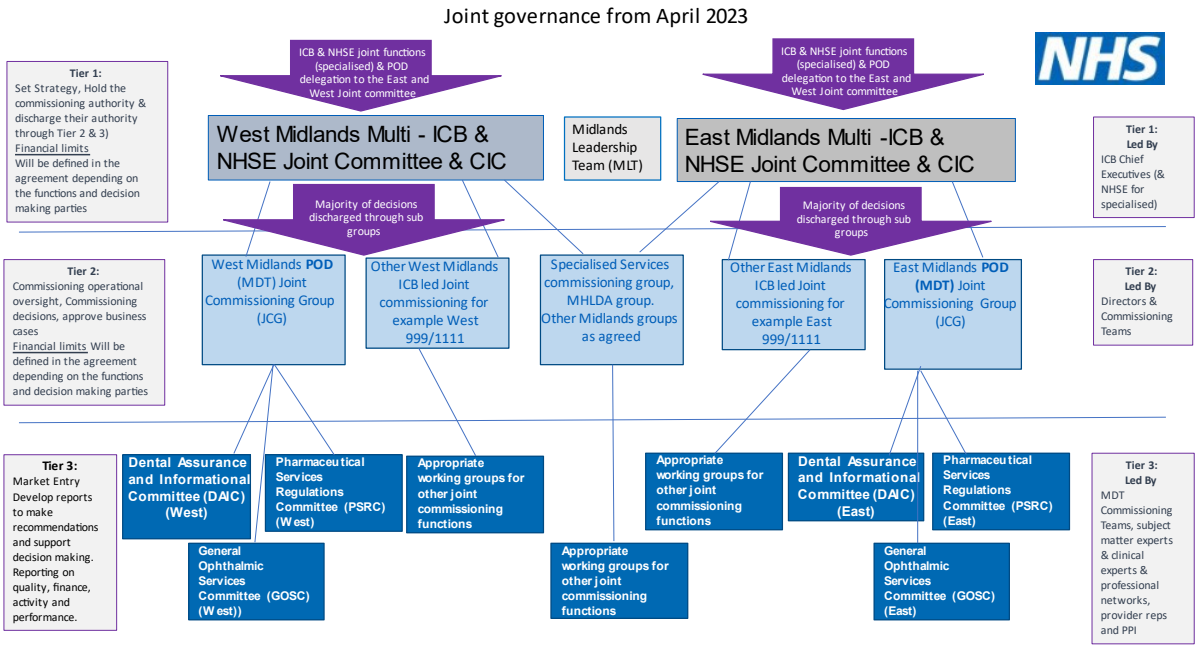


Figure 1: Joint governance from April 2023.

18. Tier 1 governance for PODs requires the establishment of a Joint Working Agreement, Joint Committee and Scheme of Reservation and Delegation across the five East Midlands ICBs. Work is ongoing to finalise these arrangements and it is anticipated that final versions will be available towards the end of February 2023. Therefore, the Board is asked to give delegated authority to the Chair and Chief Executive to finalise and approve these arrangements.

19. However, the following gives the Board an overview of the content of these documents:

Tier 1 Governance

20. The documents propose to**:**

- Establish a Joint Committee (Tier 1) of the five East Midlands ICBs underpinned by a Joint Working Agreement.
- That the Joint Committee (Tier 1) will have full delegation of commissioning functions for the prescribed services.
- That the Joint Committee (Tier 1) will be established through the Joint Working Agreement and will report into the ICB Board.

21. It is proposed that the ICB delegates to the Joint Committee (Tier 1) the responsibility for all commissioning functions for the following upon establishment:
    - Points of Delivery (PODs) name; Community Pharmacy, Dentistry and Optometry

- Specialised Commissioning
- Ambulance and NHS 111 Services.

Further functions may be added to/ removed from the Joint Committee (Tier 1) in the future by way of variation to the Joint Working Agreement.

22. The ICB will be required to reflect this delegation in their Schemes of Reservation and Delegation – this is currently being drafted and delegation is requested to the ICB Chair, CEO and Audit Chair to sign off these amendments.

19. With regard to membership and quoracy it is proposed that each ICB is represented by the Chair and CEO, with the option to nominate an appropriate deputy if required. Quorum will require a representee of each organisation to ensure "no decision about me can be taken without me".

23. With regard to decision-making it is proposed that the Joint Committee (Tier 1) will reach a decision by consensus, and that no ICB will have the authority to veto a decision reached by consensus. Where the vote relates to functions retained by NHSE then NHSE and ICB members will vote. Where the decision relates to functions delegated by NHSE to ICBs only ICB members will vote, NHSE will NOT vote in these matters.

24. The Joint Committee (Tier 1) will then establish a sub-committee/ sub-group structure (Tier 2) that will support it to discharge the delegated functions. The Joint Committee (Tier 1) will be responsible for determining and establishing this sub-structure and will therefore approve the Terms of Reference for each sub-committee/ sub-group. The Joint Committee (Tier 1) will set out how the functions will be discharged through a Scheme of Reservation and Delegation which it will be responsible for approving. For the avoidance of doubt, decision-making on delegated functions will be reserved to the structure set out above and the applicable hosted team. ICBs will only reserve decisions relating to the Joint Working Agreement.

25. It is proposed for the Joint Committee (Tier 1) to meet with the West Midlands Joint Committee on a quarterly basis through a Committee in Common approach. The two Committees will come together as a collective eleven ICBs to support collaboration on a wider Midlands planning footprint.

Tier 2 - Governance

26. The Joint Committee (Tier 1) will establish commissioning groups at "Tier 2". Through the Schemes of Reservation and Delegation the Joint Committee will set out the function and decisions each commissioning group will take.

27. It is proposed that the Joint Committee will establish a Commissioning Group for each of the service areas it has been delegated/ in preparing for delegation. As of April 2023, these will be:

- Points of Delivery (PODs)
- Specialised Commissioning (shadow form)
- Multi ICS Commissioned Services – Ambulance and NHS 111

28. The functions, duties and authorities of the Commissioning Groups will be set out in the Scheme of Reservation and Delegation. The Scheme of Reservation and Delegation is currently in draft form. In summary it is proposed for Tier 2 Commissioning Groups to have delegated responsibility for strategic and operational planning, delivery, and oversight/ assurance for their commissioning function. They will report into the Tier 1 Joint Committee.

29. The Terms of Reference will be developed through the CEO Collaborative Board and Shadow East Midlands Joint Committee. The Terms of Reference will be approved by the April 2023 meeting of the Joint Committee (Tier 1).

30. With regard to membership and quoracy it is proposed that each ICB is represented by the relevant ICB Director in accordance with the Distributed Leadership arrangements, with the option to nominate an appropriate deputy if required. NHSE will not form part of the membership for services that are delegated to/ the commissioning responsibility of ICBs. Quorum will require a representee of each organisation to ensure "no decision about me can be taken without me".

31. With regard to decision-making it is proposed that the Committee will reach a decision by consensus, and that no partner will have the authority to veto a decision reached by consensus.

32. With regard to disputes where a dispute arises that cannot be resolved by the group it will be escalated to the Joint Committee.

Tier 3 - Governance

33. The Joint Committee may establish commissioning sub-groups. These sub-groups may be subject matter specialist areas that are delegated functions and decision making through the Schemes of Reservation and Delegation.

34. Figure 1 above provides sight of the current draft Tier 3 sub-group structure. This is currently limited to those sub-groups require to deliver the PODs delegated functions and so leans heavily on the current structure in place at NHSE. Approval of the sub-group structure and associated Terms of Reference sits with the Joint Committee (Tier 1).

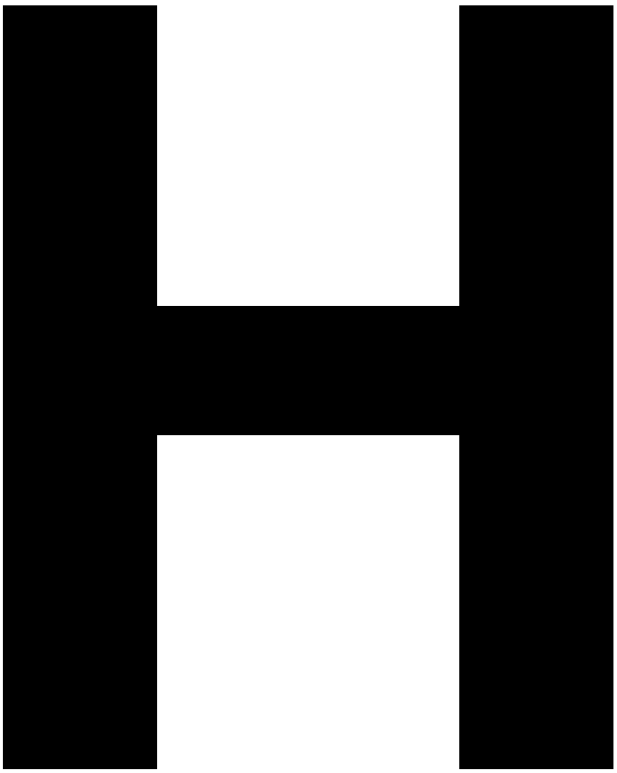
35. Sub-groups will be led by the hosted team with membership, quoracy and decision-making being driven by the parameters of the group and the principles of involvement of partners and "no decision about me made without me".

36. It is anticipated that the Scheme of Reservation and Delegation will set out function and decisions to be carried out by individual employees of the hosted team. Where this is the case, it will be the responsibility of that individual to engage with those partners to which the matter relates/ matter impacts as required to support an informed decision to be made.

Recommendations

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **APPROVE** the workforce hosting arrangements.
- **APPROVE** the Distributed Leadership arrangements.
- **APPROVE** delegated authority to the Chair and Chief Executive to consider and approve the Tier 1 governance arrangements including the Joint Working Agreement, Joint Committee Terms of Reference and Scheme of Reservation and Delegation.
- **APPROVE** delegated authority to the Chair, Chief Executive and Audit Committee Chair to approve any changes necessary to the LLR ICB governance arrangements to reflect delegation to the Joint Committee.



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board**		
Date:	9 February 2023	**Paper:**	**H**
Report title:	**Strategic Leadership Collaborations**		
Presented by:	Andy Williams, Chief Executive		
Report author:	Alice McGee, Chief People Officer		
Executive Sponsor:	Andy Williams, Chief Executive LLR ICB Toby Sanders, Chief Executive Northamptonshire ICB		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE and NOTE** the approach being explored and tested to enable sharing of professional and strategic leadership across Leicester, Leicestershire and Rutland and Northamptonshire ICBs for the People agenda.
- **NOTE** that the approach will be discussed further with the Remuneration Committee, including the intention to consider any future opportunities for sharing expertise and capacity for future roles if appropriate.
- **NOTE** that the board will evaluate the outcome of the trial period before any substantive changes are made.

Purpose and summary of the report:

This report provides an update to the LLR ICB and Northamptonshire ICB on the approach taken for sharing expertise, resource and leadership for the People agenda.

Appendices:	n/a
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	n/a

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒

5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The current BAF notes workforce being a critical risk – vacancy rates, turnover, burnout and retention issues will be addressed through have professional leadership on the People Agenda across the ICS's
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	There will be a cost sharing arrangement between the two ICB's, this will not necessarily result in large savings as operational teams will be required to deliver the people agenda
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None highlighted or identified
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	none

CONTEXT

1. Integrated Care Boards have adopted slightly different approaches to structuring their executive teams. Some roles are prescribed but there is room for local flexibility in the detailed roles and the grouping of executive functions.

2. Within the East Midlands, some executive functions are anticipated to be difficult to fill. There have been a number of conversations between Chief Executives about whether joint appointments might be a way of solving some of these role or skills challenges.

3. In December 2022, the Chief Executives of LLR and Northamptonshire ICBs considered the potential for a shared strategic People Function. This report provides the principles of a proposed arrangement. The proposed arrangement is being tested from 1st February 2023 and will be considered further by the Remuneration Committee in March.

4. Whilst this paper sets out the arrangements for the strategic partnership for the People agenda, the Chief Executives remain committed to exploring other opportunities as they may arise whilst recognising that some functions remain better discharged at each ICB.

APPROACH TO STRATEGIC PEOPLE AGENDA

5. The LLR ICB Chief People Officer has a portfolio that covers People and Workforce, Culture, Equality Diversity and inclusion, Quality Improvement, Digital Transformation, Communications and Engagement.

6. The Northamptonshire system people function has been delivered through a Chief People Officer at one of the Providers with accountability for the people function to the ICB Chief Nursing Officer. It was agreed between partners in the ICB that this arrangement would come to an end in January 2023 and the team appointed to support the ICS people agenda would transfer to the ICB, and the Chief Nursing Officer, on 9th January 2023.

7. Northamptonshire ICB have considered appointing a Band 9 Director of People, with accountability to the Chief Nurse and a job description has been developed, with budget in place, to support this. However, consideration has been given to the current market and the opportunities that sharing a strategic post between ICB's could bring.

8. The responsibilities of a CPO for an ICB have two clear functions: a) the leadership of the internal HR and OD functions for the ICB as an employing organisation and b) the leadership of the workforce and people agenda across the partners in the ICS, focussing on;
    a. The strategic leadership and coordination of the delivery of the People Plan across partner organisations in health and social care.
    b. Understanding the workforce profile to enable strong workforce planning to address workforce challenges. This element recognises the statutory functions of the partner organisations but enables a coordinated and concerted effort to tackle 'wicked' workforce challenges once and together.

c. Leadership for transformation for our workforce to meet the changing needs of our population, address health inequity and improve health outcomes. This requires considering our workforce at system, place and neighbourhood level.
d. Building trusted relationships with partners and communities, to improve integration across the system and new ways of working through adopting collaborative approaches.

9. The Chief People Officer will lead the delivery of these responsibilities across both systems with teams within each ICB, recognising that for some areas there will be opportunities for sharing resources, delivering across both ICB's and achieving economy of scale. The opportunities to solve common challenges, create teams of excellence and expertise whilst recognising that some agenda's may be better deliver at ICB level

10. The arrangements for sharing the CPO across the two ICB's will be on the basis of a 'license to operate' enabling the CPO to become an executive lead on behalf of both statutory organisations, a recharge from LLR to Northamptonshire and a review of the arrangements at 6 monthly intervals enabling any party to end the arrangement.

11. The time split between the organisations will be 1.5 days a week at Northamptonshire and 3.5 days a week at LLR. This time will be used flexibly recognising potential peaks of workload in each organisation and a new way of working in each organisation by the CPO to free capacity to provide strategic leadership across both organisations and systems.

12. This approach has been developed as a trial period to enable both organisations and the Chief People Officer to understand the impact of this joint strategic approach. The evaluation of the impact will need to consider how the approach is impacting the respective organisations whilst realising opportunities for greater collaboration. The evaluation will be led by the Chief Executives of the ICBs, and the Chief People Officer with opportunities for Board Members to contribute.

13. At the end of the trial period, should any substantive changes be proposed the evaluation will be considered by the Board who will make any final decisions about the arrangements.

RECOMMENDATIONS

14. The Integrated Care Board is asked to:

- **RECEIVE and NOTE** the approach being explored and tested to enable sharing of professional and strategic leadership across Leicester, Leicestershire and Rutland and Northamptonshire ICBs for the People agenda.

- **NOTE** that the approach will be discussed further with the Remuneration Committee, including the intention to consider any future opportunities for sharing expertise and capacity for future roles if appropriate.

- **NOTE** that the board will evaluate the outcome of the trial period before any substantive changes are made.

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board**		
Date:	9 February 2023	**Paper:**	I
Report title:	**LLR Integrated Care System People and Workforce Report**		
Presented by:	Alice McGee, Chief People Officer		
Report author:	Alice McGee, Chief People Officer		
Executive Sponsor:	Alice McGee, Chief People Officer (ICB), Clare Teeney, Chief People Officer (UHL), Sarah Willis, Director of HR and OD (LPT)		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the People and Workforce report, noting the headline figures and how this information drives forward our priorities set at the LLR People and Culture Board
- **FOR ASSURANCE** note the governance and assurance processes for the People risks and programmes of work

Purpose and summary of the report:

The LLR ICS People and Culture Board has been established since 2020 with formal reporting into the Midlands NHS England People and Culture Board and since July 2022 into the LLR System Executive. This report provides a summary of the programmes of work, strategic direction and the operational workforce planning that is considered at the People and Culture Board.

The People and Culture Board has a membership across ICS partners (health and social care) and its sub groups have in some instances wider membership to include the voluntary, community and social enterprise sector as well as other public sector bodies (fire and police).

Appendices:	• Appendix 1 - January 2022 Workforce Dashboard
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒

3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The current BAF notes workforce being a critical risk – vacancy rates, turnover, burnout and retention issues will be addressed through looking at our data and the impact of our interventions
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Identifying overspend on current agency and substantive workforce.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None highlighted in current data pack and will be shared with Quality committee to ensure this is triangulated
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	none

CONTEXT

1. The LLR ICS People and Culture Board has been established since 2020 with formal reporting into the Midlands NHS England People and Culture Board and since July 2022 into the LLR System Executive.

2. Workforce reports detailing recruitment against operational plan and agency spend information for LPT and UHL are routinely presented to ICB Finance Committee and ICB Quality Committee. Both committees receive the information to triangulate with their own data and assurances ensuring that workforce remains the critical responsibility for all parts of our system.

3. The ICS People and Culture Board is responsible for assuring itself of progress against the People Plan (nationally set) and progressing towards its long term vision. Since 2020 the strategic aim of the ICS People and Culture Board has been:

    a. Shape our people and services around the needs of our population
    b. Build a One Team, One People Culture
    c. Maximise the people potential of the LLR population and support wider economic and social recovery

4. In November 2022 the People and Culture Board explored the concept of a one workforce approach to integration, culture, retention and recruitment. The workshop developed a set of characteristics that would describe what this would look like for our organisations and our people. Further work to progress this concept is continuing in 2023 and will develop LLR's first strategic workforce plan in line with the new national framework for strategic workforce planning (due to be published in March 2023).

5. The People Board and its subsequent sub groups have a responsibility to consider the strategic approach to workforce development and culture as well as responding to the immediate challenges of our workforce. This has been particularly shown through Industrial Action planning where People Leaders collectively worked together to understand the impacts of Industrial Action, respond consistently and together whilst recognising that part of the role of the People Board is to improve culture, retention and recruitment on a long term basis.

6. Through the operational and strategic planning cycle, the workforce leads across our health and care partners will be working together to set the workforce plan and strategic plan for the next 5 years. This will provide the system with an oversight of the detailed workforce trajectories for the next 12 months whilst also setting the longer term plan for workforce growth, supply and ambition for our workforce. These plans will be focussed on the health element of our workforce for submission to NHS England however the People Board and its members will ensure that this work is inclusive of the social care workforce.

PEOPLE PLAN PRIORITIES

7. In 2020 NHS England published the People Plan which was the first strategic plan for the NHS. In LLR the People Board reviewed the content of the People Plan and translated it into a set of work programmes that included health and social care.

8. The LLR People Plan work programmes each has a sub structure that connects the constituent organisational priorities to the system vision and priorities ensuring that the work done together is adding value and helping us collectively reach our goals of higher staff satisfaction, retention and recruitment.

9. Diagram 1 shows the overall programme infrastructure for delivering the People Plan. Each of the programmes of work has a executive lead and a senior programme lead, some of the leadership comes from the ICB, others comes from partner organisations. The executive lead is responsible for reporting to the People and Culture Board on progress and reviewing the annual priorities, aligned to national priorities and funding.

10. Diagram 2 shows an example of a work programme overview that has a routine spotlight to review outcomes and progress

11. It is important that the People Plan priorities compliment the overarching ICB objectives and priorities. In setting the objectives of each of the workstreams the leads are required to set out what the expectation is of delivery, impact, timescales and resources required to achieve the outcomes. This is particularly important when the short term priorities may change and additional people support is needed. This is demonstrated in the context of Looking After Our People where we recognised additional support through Winter was needed for our clinical staff and programme of short term work which reaches into clinical teams has commenced. This includes fast track employee assistant, Swartz Rounds and access to psychological services.

12. It is recognised by the People Board that there are multiple connected programmes of work. Simplistically, each of the programmes have a responsibility to support the attraction, retention and development of workforce where it makes sense to do this once together. The People Board has a role to understand the connectivity of the programmes of work and ensure that the time, energy and outputs remain a priority for the system and our organisations.

Diagram 1 – People Board Overview

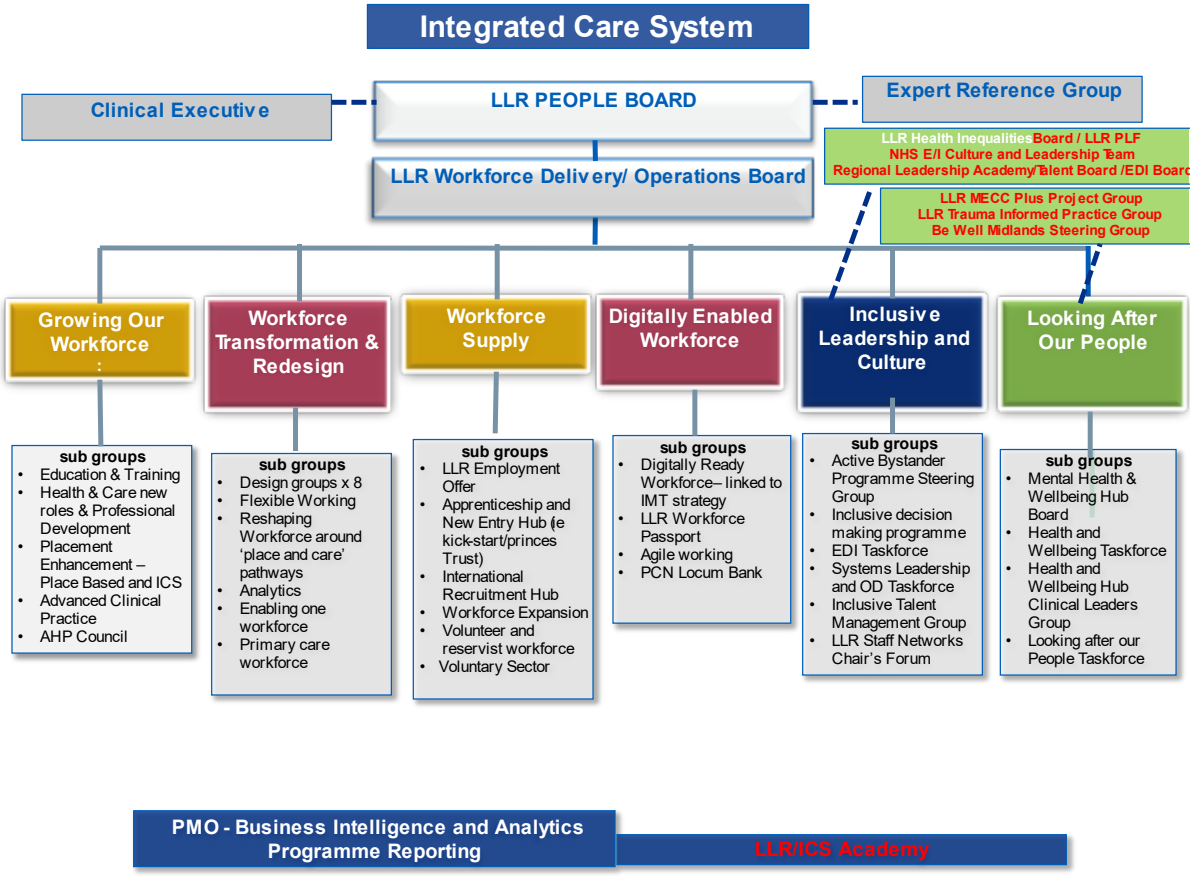


Diagram 2 – Inclusive Culture and Leadership workstream overview

Systems Leadership and OD	Rebecca Carlin, Steve Gulliver, Bina Kotecha. Ruth Lake, Amy Huckle and
Leadership Development Offerings and Catalogue	
Collaborating to Improve Care	
Coaching, Mentoring and Buddying	
ICS Senior Leadership Development Programme	
Professional Leadership Forum	Claire Ellwood, Chris West, Steph O'Connell, Caroline Tote and Dr Anu Rao
Developing a Multi-Professional Leadership Strategy	
Inclusive Talent Management	Bina Kotecha, Ruth Lake Steve Gulliver, Rebecca Carlin, Amy Huckle and Regional TM Team
BAME Nursing and Midwifery Development Programme	
Inclusive Approach / Making an Improvement Happen	
Developing Diverse Leadership	

Equality, Diversity and Inclusion Taskforce	Haseeb Ahmad, Sandy Zavery, Kate Gallopi, Bina Kotecha, Ruth Lake
Inclusive Decision Making Framework	
Reverse Mentoring	
Active Bystander Programme /Your Voice Tool	
ICS Staff Networks	
Cultural Competency Programme	
WREI Strategy / 6 High Impact Recruitment Actions	
Health Inequalities Champions	Mark Pierce, Steve McCue, Bina Kotecha and Rebecca Carlin
Development Programme	
Quality Improvement	Liz McIntyre, Ben Shaw, Moira Durbridge and Fay Bayliss
Creating a QI Movement	

WORKFORCE DASHBOARD

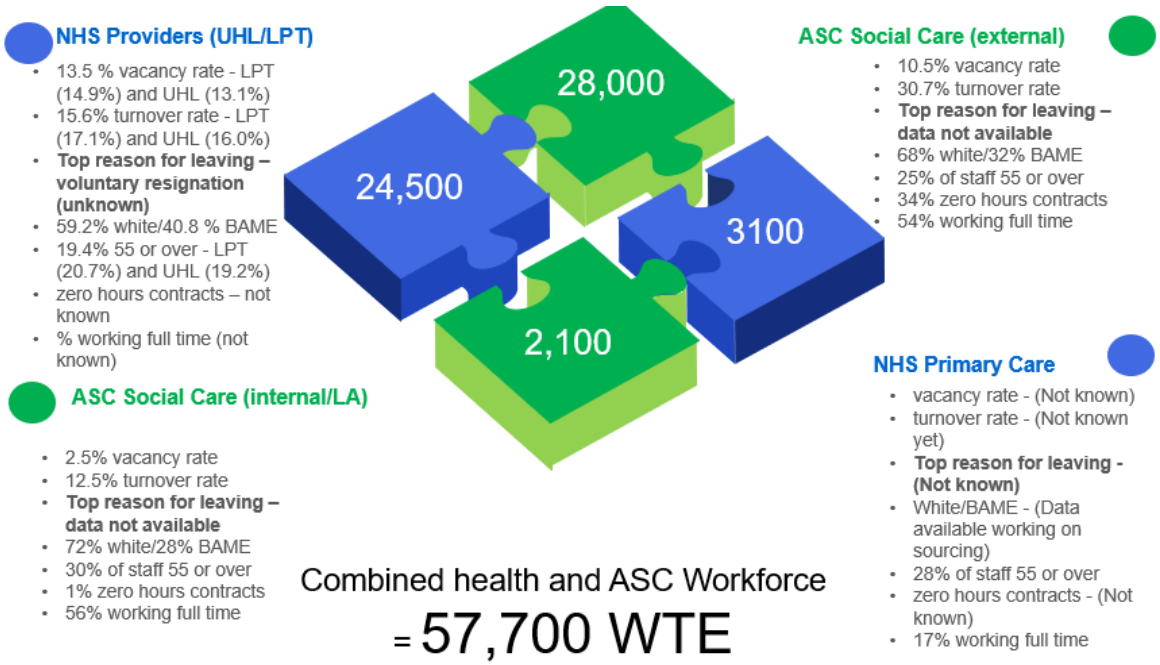
13. Appendix 1 is the monthly workforce dashboard report received and reviewed by the People and Culture Board. This data is continuously being improved upon as the People and Culture Board explore how the data becomes the insights for decision making and prioritisation.

14. The data about our workforce enables us to continuously review whether the programmes of work are focussing on the right priorities in the short and long term. For example, in September 2022 it was identified that the City Primary Care workforce was not growing at the expected rate, and in some instances declining this was declining. This data enabled the work programme to be adjusted to focus on understanding the challenges and put interventions in that allowed us to see an improvement in recruitment and retention in the short term.

15. LLR was successful in becoming one of 12 pilot sites for a national programme called 'people exemplar'. The pilot has the aim of fast-tracking understanding about retention for the NHS and using this data to help shape interventions that can be shared and replicated nationally. In LLR we have expanded our programme to other parts of the ICS and understanding the data alongside the workforce dashboard.

16. Diagram 3 shows the current understanding of our workforce, including the significant gaps across the key sectors that the programme has focussed on. In January 2023 the People Board spent time discussing the data and the priorities that the programme will focus on in 2023 to support the retention programme.

Diagram 3 – People Promise Exemplar data



ICB AS AN EMPLOYER

17. LLR ICB employ a headcount of 320 people (282.8WTE) in a variety of roles to discharge its duties as a statutory body, and support delivery of the integrated care system's priorities and its vision.

18. There is not a formal committee that considers the people and workforce profile of the ICB as an employing body. Other ICS partners, such as UHL and LPT, have approached assurance on the workforce agenda in different ways. Some have set up formal assurance committees, led by non-executive directors, others have set the agenda as an executive function led by the Chief People Officer and other executives.

19. The ICB reviews its workforce profiles, including its staff survey results, through the Executive Management Team and the Operational Delivery Group. Discussions are currently taking place to strengthen the oversight of the ICB workforce profile by expanding the ICB Remuneration Committee remit to include regular updates on the workforce metrics.

RECOMMENDATIONS

20. The Integrated Care Board are asked to
    a. RECEIVE the People and Workforce report, noting the headline figures and how this information drives forward our priorities set at the LLR People and Culture Board
    b. FOR ASSURANCE note the governance and assurance processes for the People risks and programmes of work

Appendix 1

LLR Workforce Plan Vs Actuals Month 9

UHL & LPT December Update. FY 22/23

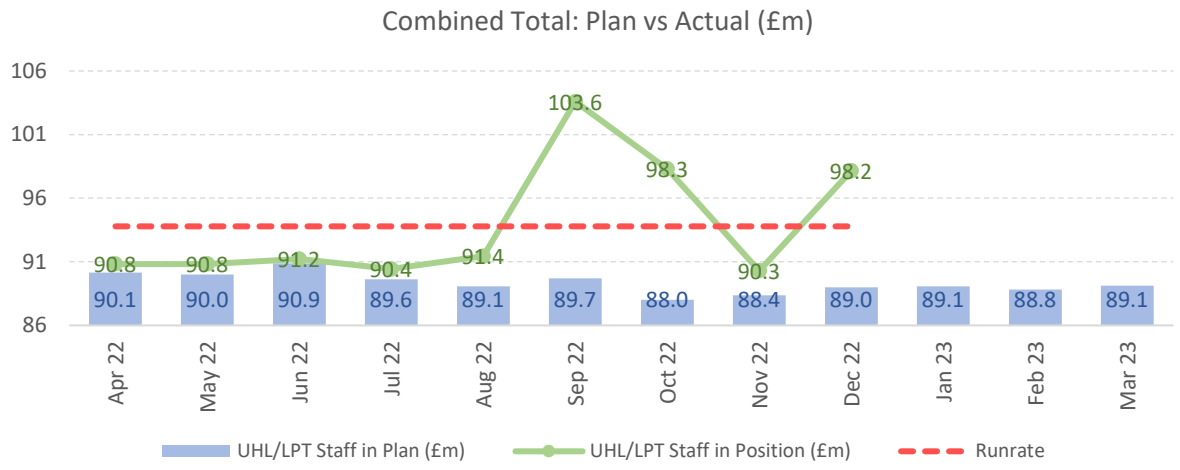
Produced by Rajesh Thanki LLR Senior Workforce Planning & BI Manager
(P&I Directorate)

UHL & LPT Combined View

Workforce Expenditure and WTE Delivery Against plan

Overview (UHL & LPT Combined £m)

UHL/LPT Variance to Plan (£m)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Total	Run Rate
Nursing, Midwifery	-0.4	-0.4	-0.9	-1.2	-0.3	0.6	-0.1	0.5	0.2	-2.0	-2.6
Scientific, Therapeutic, Technical	0.5	0.5	4.1	1.4	1.4	3.4	1.9	2.0	2.0	17.1	22.8
Ambulance service										0.0	0.0
Clinical Support	-6.0	-6.0	13.5	1.2	-0.2	3.3	1.0	0.4	1.1	8.3	11.0
Infrastructure Support	1.0	1.0	-8.5	-2.3	-0.9	1.9	0.5	0.2	2.4	-4.7	-6.3
Medical, Dental	-0.3	-0.2	1.2	-0.6	0.7	1.4	0.4	-0.3	0.5	2.7	3.6
Other staff	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2	0.5	0.7
Total Substantive	**-0.4**	**-0.4**	**-0.1**	**-1.4**	**0.7**	**10.6**	**3.8**	**2.9**	**6.3**	**22.0**	**29.3**
Total Bank	**0.5**	**0.5**	**0.0**	**0.9**	**1.0**	**2.1**	**1.5**	**1.3**	**1.6**	**9.5**	**12.7**
Total Agency	**0.6**	**0.6**	**0.4**	**1.3**	**0.7**	**1.2**	**4.9**	**-2.3**	**1.3**	**8.8**	**11.7**
Total	**0.7**	**0.8**	**0.3**	**0.8**	**2.4**	**13.9**	**10.3**	**1.9**	**9.2**	**40.3**	**53.8**



Graph above include bank and agency

The finance data represented is from the Provider Finance Return which is reported each month on the 15th.

- UHL and LPT is currently £40.3m overspend against finance plan
  - UHL are +£22.9m against target FYTD
  - LPT are +£17.5m against target FYTD
- LPT agency is continuing to be over budget on agency
- Substantive is £9.8m overspent in UHL FYTD. UHL was underspent until Sep.

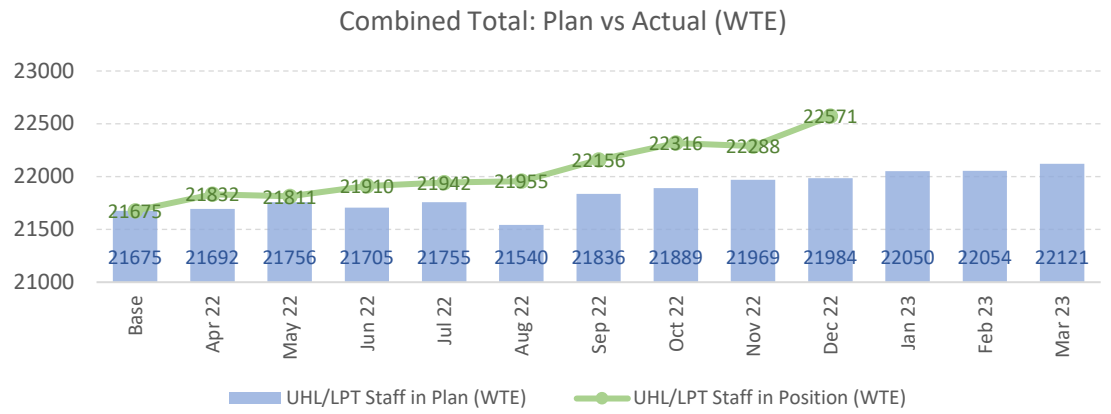
	VARIANCE										
Agency Spend (£m)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	TOTAL
UHL (In Month)	4113	0.3	0.2	-0.3	0.5	0.2	0.5	4.2	-3.1	0.2	2.7
LPT (In Month)	1678	0.4	0.4	0.7	0.8	0.5	0.7	0.7	0.8	1.1	6.1
Total (In Month)	**5791**	**0.6**	**0.6**	**0.4**	**1.3**	**0.7**	**1.2**	**4.9**	**-2.3**	**1.3**	**8.8**
Total (Cumulative)		**0.6**	**1.2**	**1.6**	**2.9**	**3.7**	**4.9**	**9.8**	**7.5**	**8.8**	**9.8**

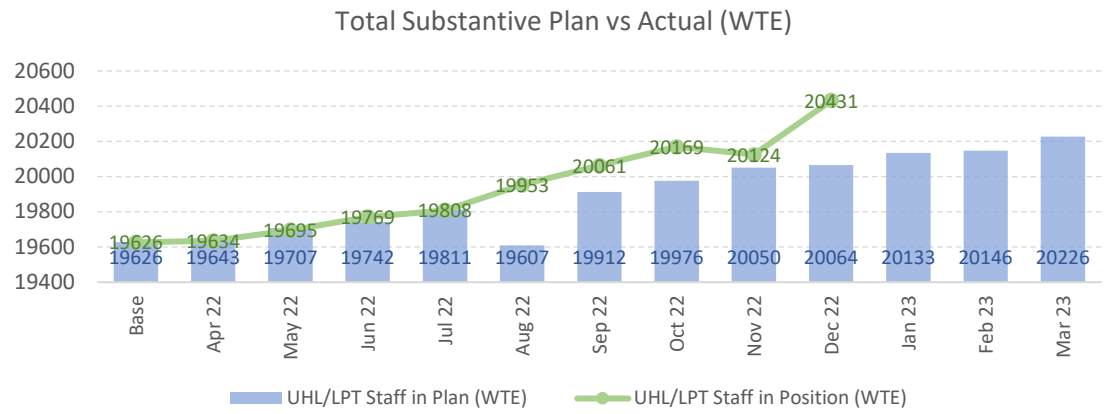
Overview (UHL & LPT Combined WTE)

UHL/LPT Variance to Plan (WTE)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Average
Nursing, Midwifery	-24	-29	-22	-32	-34	-17	-25	48	48	-10
Scientific, Therapeutic, Technical	58	48	43	35	42	62	74	69	87	57
Ambulance service	0	0	0	0	0	0	0	0	0	0
Clinical Support	0	14	36	35	62	64	112	139	210	75
Infrastructure Support	-36	-24	-6	-6	235	9	11	-221	-10	-5
Medical, Dental	-7	-21	-24	-35	40	32	22	38	33	9
Other staff										
Total Substantive	**-9**	**-12**	**28**	**-3**	**345**	**149**	**193**	**73**	**367**	**126**
Total Bank	**-35**	**-96**	**-29**	**-47**	**4**	**39**	**8**	**69**	**21**	**-7**
Total Agency	**183**	**163**	**206**	**237**	**66**	**133**	**226**	**176**	**199**	**177**
Total	**140**	**55**	**205**	**187**	**415**	**321**	**427**	**319**	**587**	**295**
Variance to Plan %	**0.0%**	**-0.1%**	**0.1%**	**0.0%**	**1.8%**	**0.7%**	**1.0%**	**0.4%**	**1.8%**	**0.6%**

The TUPE transfer did not going ahead as planned in August and has gone through on 01/11/22.

- UHL and LPT is at +4.1% substantive growth vs. planned at 2.2%.
- UHL are +172 WTE against target average per month (Substantive).
- LPT are -46 WTE against target average per month (Substantive).
- LPT agency use average +144 WTE per month.
- In December Clinical support is the main driver for agency use across UHL and LPT (+37 WTE in UHL and +92 WTE in LPT clinical support agency).





Graph above include bank and agency

Overview (Combined Vacancy/Agency)

UHL/LPT PWR Vacancies (WTE)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Nursing, Midwifery	967	985	1069	1106	1092	1096	1038	1030	964	958
Clinical Support	438	444	534	512	539	623	728	670	591	653
Infrastructure Support	680	830	810	837	832	783	763	716	671	670
Medical, Dental	125	153	211	214	226	183	193	225	214	211
All Other	351	287	387	386	398	364	332	333	318	313
Total	**2911**	**2699**	**3011**	**3056**	**3087**	**3050**	**3053**	**2974**	**2758**	**2805**
Vacancy Rate	**12.9%**	**12.1%**	**13.3%**	**13.4%**	**13.5%**	**13.3%**	**13.2%**	**12.9%**	**12.1%**	**12.1%**

Vacancies are 4% below base (March 22) across UHL & LPT.

- Medical and dental has the highest vacancy increase at 69% above base.
- Clinical support is the second highest vacancy increase at 49% above base.

	Agency VARIANCE									
UHL/LPT Variance to Plan (WTE)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Nursing, Midwifery	4113	62	59	84	84	50	60	57	57	77
Scientific, Therapeutic, Technical	1678	-26	-37	-16	-11	12	-10	-7	18	11
Ambulance service	8									
Clinical Support	4250	142	105	125	90	72	77	169	153	129
Infrastructure Support	2384	21	57	39	58	-67	-12	-8	-67	2
Medical, Dental	2248	-17	-20	-25	16	-1	17	14	15	-20
Other staff	0									
Total		**183**	**163**	**206**	**237**	**66**	**133**	**226**	**176**	**199**

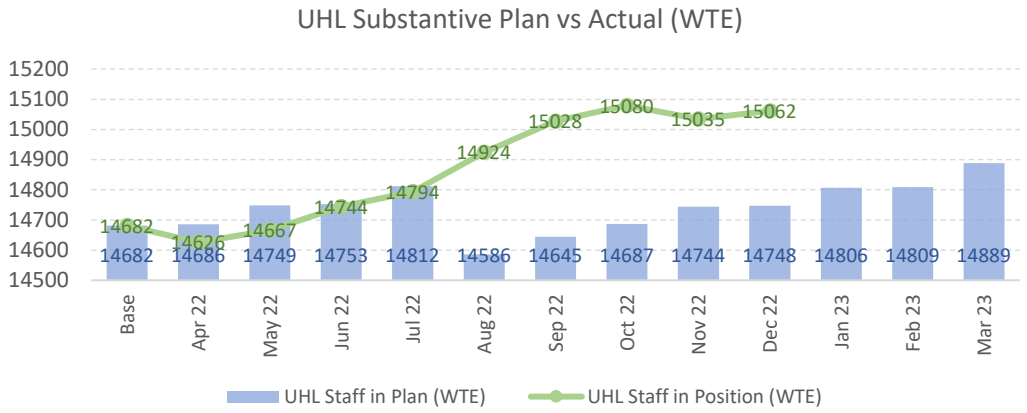
- Clinical support agency use has the highest variance to plan at +129 WTE.
- Nurse, Midwifery has the second highest variance to plan at +77 WTE.

UHL

Workforce Expenditure and WTE Delivery Against Plan

UHL View

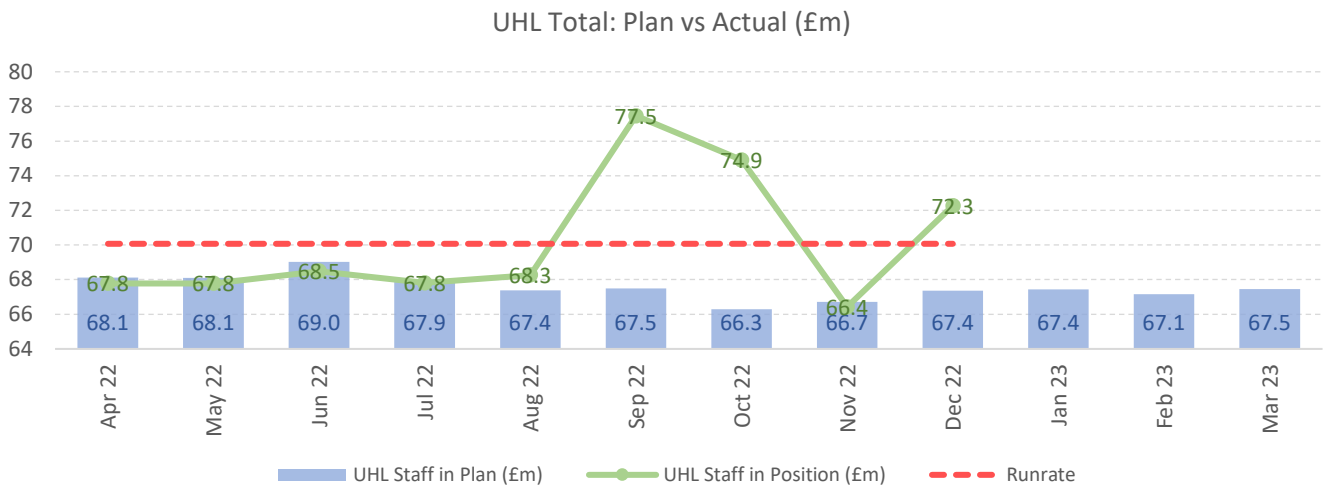
UHL Variance to Plan (WTE)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Average
Nursing, Midwifery	-19	-20	13	16	31	42	49	123	125	40
Scientific, Therapeutic, Technical	-9	-24	-25	-33	-29	-4	5	4	4	-12
Ambulance service	0	0	0	0	0	0	0	0	0	0
Clinical Support	-23	-18	2	6	50	63	72	112	149	46
Infrastructure Support	6	7	29	30	263	266	262	30	22	102
Medical, Dental	-15	-28	-27	-37	24	16	5	22	14	-3
Other staff										
Total Substantive	**-60**	**-82**	**-8**	**-19**	**338**	**383**	**393**	**290**	**314**	**172**
Total Bank	**-9**	**-81**	**-9**	**-13**	**36**	**55**	**19**	**62**	**15**	**8**
Total Agency	**9**	**-8**	**-26**	**36**	**-10**	**47**	**96**	**86**	**66**	**33**
Total	**-60**	**-172**	**-44**	**4**	**364**	**485**	**508**	**438**	**394**	**213**
Variance to Plan %	**-0.4%**	**-0.6%**	**-0.1%**	**-0.1%**	**2.3%**	**2.6%**	**2.7%**	**2.0%**	**2.1%**	**1.2%**



- UHL is at +2.6% substantive growth vs. planned at 0.5%.
- UHL are +172 WTE against target average per month (Substantive).
- In December Clinical support is the main driver for agency use across UHL and LPT (+37 WTE).

Overview (UHL £m)

UHL Variance to Plan (£m)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Total	Run Rate
Nursing, Midwifery	-0.4	-0.4	-0.2	-0.3	-0.3	1.4	0.0	0.1	0.1	-0.1	-0.1
Scientific, Therapeutic, Technical	0.0	-0.1	3.6	0.7	0.8	1.8	1.2	1.1	1.2	10.4	13.8
Ambulance service										0.0	0.0
Clinical Support	-5.2	-5.2	14.3	2.1	0.7	3.2	1.7	0.8	1.4	13.7	18.3
Infrastructure Support	-0.2	-0.2	-10.1	-3.6	-2.3	0.3	-0.3	-0.3	0.1	-16.5	-22.0
Medical, Dental	-0.3	-0.2	1.2	-0.5	0.6	1.0	0.4	-0.3	0.5	2.3	3.1
Other staff										0.0	0.0
Total Substantive	**-1.3**	**-1.3**	**-0.8**	**-1.6**	**-0.5**	**7.7**	**2.9**	**1.4**	**3.3**	**9.8**	**13.0**
Total Bank	**0.7**	**0.8**	**0.5**	**1.0**	**1.2**	**1.7**	**1.5**	**1.4**	**1.4**	**10.3**	**13.8**
Total Agency	**0.3**	**0.2**	**-0.3**	**0.5**	**0.2**	**0.5**	**4.2**	**-3.1**	**0.2**	**2.7**	**3.6**
Total	**-0.3**	**-0.3**	**-0.5**	**0.0**	**0.9**	**10.0**	**8.6**	**-0.3**	**4.9**	**22.9**	**30.5**



Graph above include bank and agency

- UHL is currently £22.9m overspend against finance plan YTD
- Substantive is £9.8m overspend YTD which clinical support and Scientific, Therapeutic, Technical being the largest drivers of overspend.

Overview (UHL Vacancy/Agency)

UHL PWR Vacancies (WTE)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Nursing, Midwifery	566	596	649	654	619	634	591	619	550	565
Clinical Support	277	293	382	352	395	376	392	416	409	388
Infrastructure Support	664	712	687	716	719	722	709	670	620	615
Medical, Dental	104	112	164	165	175	139	146	183	173	178
All Other	314	262	299	304	309	293	271	277	275	264
PWR reported Vacancies	**2238**	**1975**	**2182**	**2192**	**2217**	**2165**	**2109**	**2164**	**2027**	**2011**
Vacancy Rate	**13.2%**	**11.9%**	**12.9%**	**12.9%**	**13.0%**	**12.7%**	**12.3%**	**12.6%**	**11.9%**	**11.8%**

Vacancies are 10% below base (March 22) across UHL.

- Medical and dental has the highest vacancy increase at 71% above base.
- Clinical support is the second highest vacancy increase at 40% above base.

Agency VARIANCE										
UHL Variance to Plan (WTE)	**Base**	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	**Dec 22**
Nursing, Midwifery	4113	-12	-3	3	11	12	19	9	16	20
Scientific, Therapeutic, Technical	1678	-27	-43	-25	-11	12	-10	-10	15	7
Ambulance service	8									
Clinical Support	4250	31	9	-10	-16	-3	-4	56	67	37
Infrastructure Support	2384	35	43	32	47	-22	37	41	-14	34
Medical, Dental	2248	-19	-14	-25	5	-9	5	-1	2	-32
Other staff	0									
Total		**9**	**-8**	**-26**	**36**	**-10**	**47**	**96**	**86**	**66**

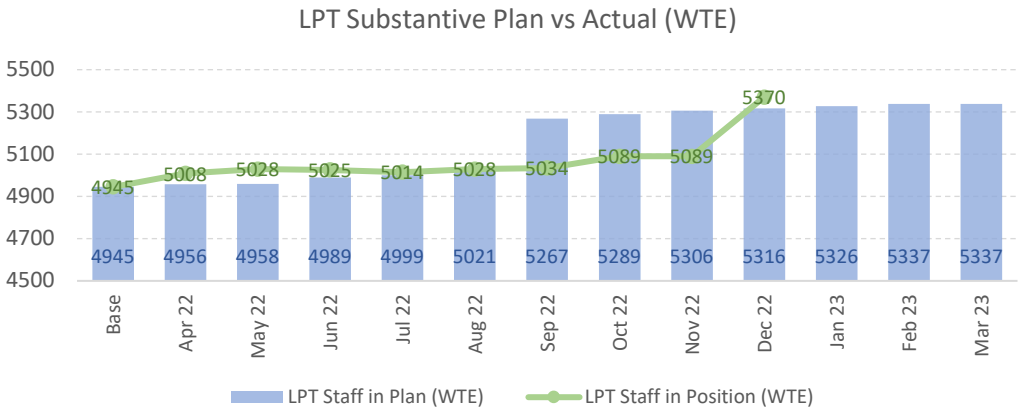
- Clinical support agency use has the highest variance to plan at +37 WTE.

LPT

Workforce Expenditure and WTE Delivery Against Plan

LPT View

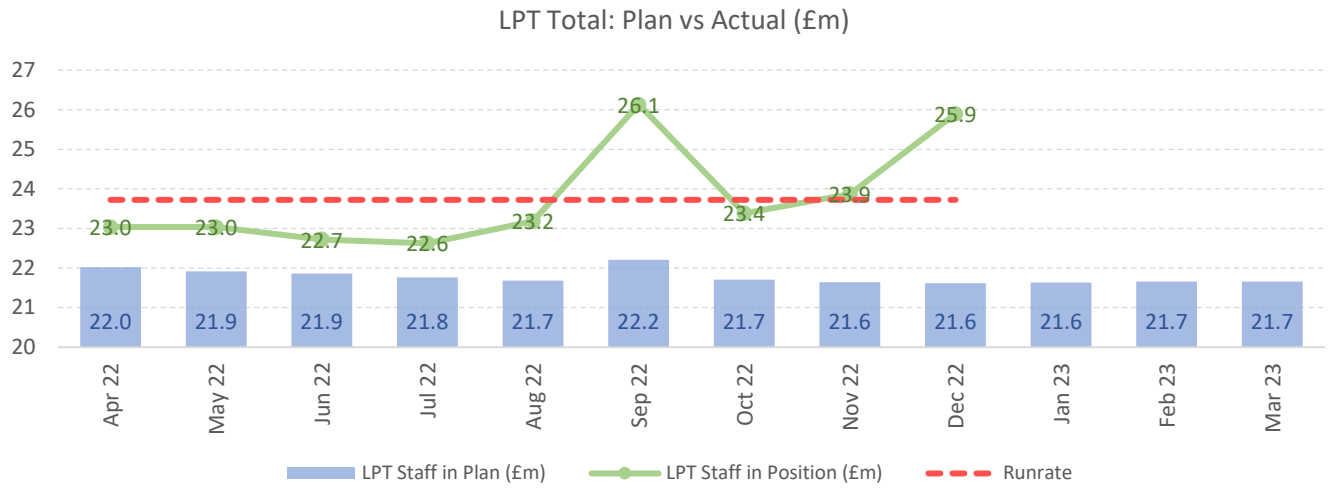
LPT Variance to Plan (WTE)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Average
Nursing, Midwifery	-5	-9	-35	-49	-64	-59	-74	-75	-77	-50
Scientific, Therapeutic, Technical	68	71	68	68	71	66	69	65	83	70
Ambulance service										
Clinical Support	23	33	34	29	13	1	39	27	61	29
Infrastructure Support	-42	-32	-35	-35	-28	-257	-251	-251	-32	-107
Medical, Dental	7	7	4	2	16	16	17	16	19	12
Other staff										
Total Substantive	**52**	**70**	**36**	**15**	**7**	**-233**	**-200**	**-217**	**53**	**-46**
Total Bank	**-26**	**-15**	**-20**	**-33**	**-32**	**-16**	**-11**	**7**	**6**	**-16**
Total Agency	**174**	**172**	**233**	**202**	**76**	**85**	**130**	**91**	**133**	**144**
Total	**200**	**227**	**249**	**184**	**52**	**-164**	**-81**	**-120**	**193**	**82**
Variance to Plan %	**1.0%**	**1.4%**	**0.7%**	**0.3%**	**0.1%**	**-4.4%**	**-3.8%**	**-4.1%**	**1.0%**	**-0.9%**



- LPT is at +8.6% substantive growth vs. planned at 7.5%.
- LPT are -46 WTE against target average per month (Substantive).
- LPT agency use average +144 WTE per month.
- In December Clinical support is the main driver for agency use across UHL and LPT (+92).

Overview (LPT £m)

LPT Variance to Plan (£m)	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Total	Run Rate
Nursing, Midwifery	0.0	0.0	-0.7	-0.9	0.0	-0.8	-0.1	0.4	0.1	-1.9	-2.5
Scientific, Therapeutic, Technical	0.5	0.5	0.5	0.7	0.6	1.5	0.7	0.9	0.8	6.8	9.0
Ambulance service										0.0	0.0
Clinical Support	-0.8	-0.8	-0.8	-0.9	-0.9	0.1	-0.6	-0.3	-0.3	-5.4	-7.2
Infrastructure Support	1.2	1.2	1.7	1.3	1.4	1.5	0.9	0.5	2.3	11.8	15.7
Medical, Dental	0.0	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.4	0.6
Other staff	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2	0.5	0.7
Total Substantive	**0.9**	**1.0**	**0.7**	**0.2**	**1.2**	**2.9**	**0.9**	**1.5**	**3.0**	**12.2**	**16.3**
Total Bank	**-0.2**	**-0.2**	**-0.5**	**-0.2**	**-0.2**	**0.4**	**0.1**	**-0.1**	**0.2**	**-0.8**	**-1.1**
Total Agency	**0.4**	**0.4**	**0.7**	**0.8**	**0.5**	**0.7**	**0.7**	**0.8**	**1.1**	**6.1**	**8.1**
Total	**1.0**	**1.1**	**0.9**	**0.9**	**1.5**	**3.9**	**1.7**	**2.2**	**4.3**	**17.5**	**23.3**



Graph above include bank and agency

- LPT is currently £17.5m overspend against finance plan YTD
- Substantive is £12.2m overspend YTD which Infrastructure Support and Therapeutic, Technical being the largest drivers of overspend.

Overview (LPT Vacancy/Agency)

LPT PWR Vacancies (WTE)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Nursing, Midwifery	401	388	421	452	473	462	446	411	414	393
Clinical Support	161	151	152	159	144	248	337	254	182	266
Infrastructure Support	17	119	122	121	113	60	54	46	52	54
Medical, Dental	21	42	47	49	50	45	47	42	41	32
All Other	37	24	87	82	89	70	61	56	43	48
PWR reported Vacancies	**673**	**724**	**830**	**864**	**869**	**885**	**944**	**810**	**731**	**794**
Vacancy Rate	**12.0%**	**12.6%**	**14.2%**	**14.7%**	**14.8%**	**15.0%**	**15.8%**	**13.7%**	**12.6%**	**12.9%**

Vacancies are 18% above base (March 22) across UHL & LPT.

- Infrastructure Support has the highest vacancy increase at 227% above base.

LPT implemented ESR vacancy reporting in June 2022 and have been actively working on data quality over the following months. From June 2022 onwards, fluctuations in vacancy numbers are caused by corrections to budgeted establishments and corrections to coding of posts in ESR, as well as normal staff movements (starters and leavers).

Agency VARIANCE										
LPT Variance to Plan (WTE)	**Base**	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	**Dec 22**
Nursing, Midwifery	4113	74	62	81	74	38	41	48	41	57
Scientific, Therapeutic, Technical	1678	1	6	9	0	0	0	3	3	4
Ambulance service	8									
Clinical Support	4250	111	96	135	105	75	81	113	86	92
Infrastructure Support	2384	-14	14	7	11	-46	-49	-49	-52	-32
Medical, Dental	2248	2	-6	0	11	9	12	15	13	12
Other staff	0									
Total		**174**	**172**	**233**	**202**	**76**	**85**	**130**	**91**	**133**

- Clinical support agency use has the highest variance to plan at +92 WTE.
- Nursing has the second highest variance to plan at +57 WTE.

Primary Care

Appendix

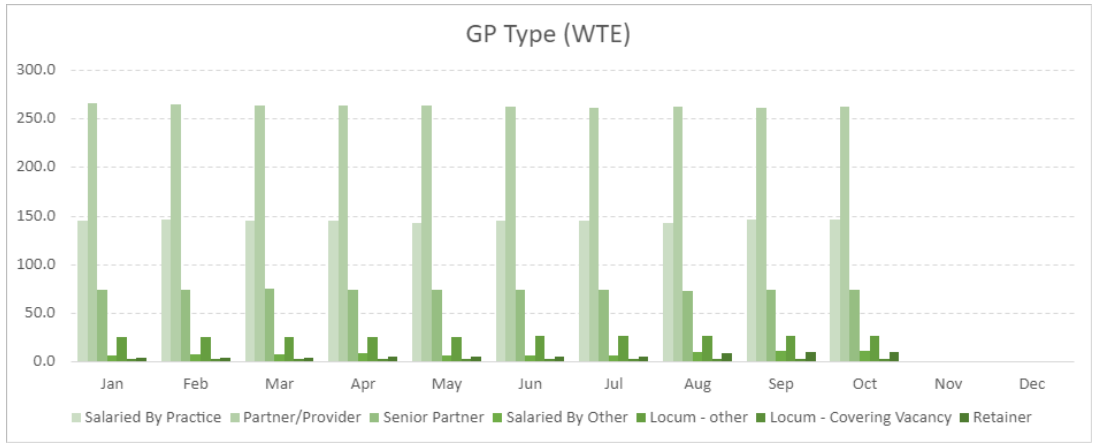
December 2022 Primary Care Workforce

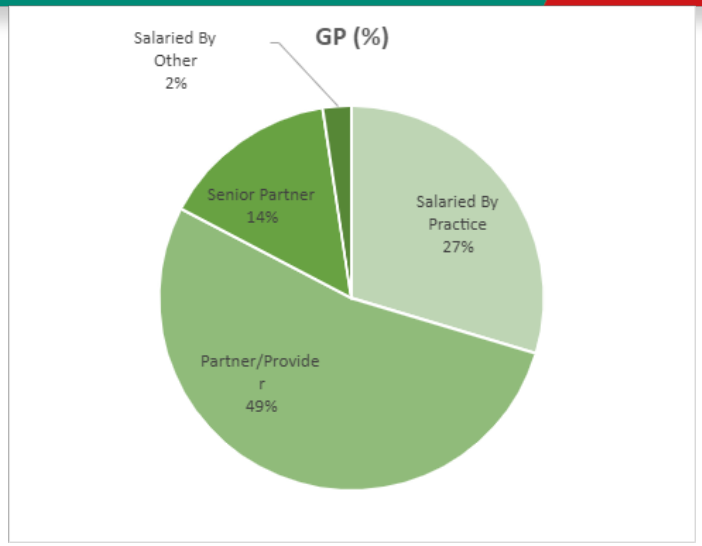
Primary Care - Leicester, Leicestershire And Rutland	Year End (31-Mar-22)	Q1	Q2	Q3	Q4
Total Workforce	2738.8	2830.5	2908.5	2974.6	3041.5
GPs excluding registrars	522.8	527.8	531.0	534.2	537.4
Nurses	279.6	282.0	284.9	284.5	285.5
Direct Patient Care roles (ARRS funded)	277.3	324.0	371.0	418.0	465.0
Direct Patient Care roles (not ARRS funded)	306.1	313.0	320.6	330.1	337.8
Other – admin and non-clinical	1352.9	1383.7	1401.0	1407.8	1415.8
Primary Medical Care	2461.4	2506.5	2537.5	2556.6	2576.5

Based on plans submitted to NHSEI

- GP workforce numbers is currently on plan as of December 2022
- Nurse workforce numbers was on plan until September which saw a decline in WTE and is now -5.7 WTE behind plan.
- ARRS role claims are -16 WTE behind plan as of data from July 2022 however MHP roles are not included in the figures which sits at approximately 18 FTE. August data did not have total claims and could not be used.
- DPC roles (Non ARRS) are only 1 WTE behind plan.
- Admin roles are 6 WTE behind plan. However the gap is closing and has been for the past 3 months.

Primary Care GP and ARRS





ARRS Staff Groups	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
Clinical Pharmacist	110.6	111.4	131.9	134.7	141.5	142.0	163.2	151.4	158.3	157.4	134.1
Pharmacy Technician	19.6	17.5	22.3	22.1	21.1	23.1	24.3	25.8	24.4	26.6	20.0
Social Prescribing Link Worker	37.5	32.4	48.5	43.8	42.8	45.6	48.4	45.6	42.3	50.3	39.1
Health and Wellbeing Coach	9.0	8.0	7.0	6.5	8.9	8.2	8.6	11.6	12.5	15.6	12.7
Care Coordinator	21.7	18.7	21.7	21.8	26.8	26.7	28.3	32.9	30.6	30.7	25.4
Physician Associate	28.1	25.2	27.3	28.1	29.1	31.1	31.7	31.7	31.6	32.4	32.4
First Contact Physiotherapist	34.7	15.4	42.4	24.1	23.4	21.4	23.3	22.4	21.2	20.4	13.4
Dietician	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Podiatrist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Occupational therapist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing associate	13.8	12.3	13.3	11.5	15.7	16.1	16.1	16.7	15.4	19.1	12.3
Trainee nursing associate	4.0	4.6	4.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	2.8
Advanced Practitioner	5.4	3.4	7.4	5.4	5.4	6.4	6.4	6.4	6.4	2.0	2.0
Paramedic	30.2	11.2	11.2	13.4	15.4	17.5	22.0	23.6	25.6	23.8	8.4
Mental Health Practitioner Band 6	1.0	7.0	2.0	5.0	3.0	2.0	4.3	5.0	2.0	3.0	2.0
Mental Health Practitioner Band 7	4.0	11.0	14.0	11.1	13.1	11.1	12.1	15.1	15.1	15.9	10.1
Mental Health Practitioner Band 8a	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0
Total	319.5	278.2	353.7	331.4	351.1	354.8	392.4	391.9	390.2	401.9	314.6
Agency based	61.7	22.7	100.8	50.6	57.4	47.1	75.8	61.5	49.3	59.4	44.3

Care sector

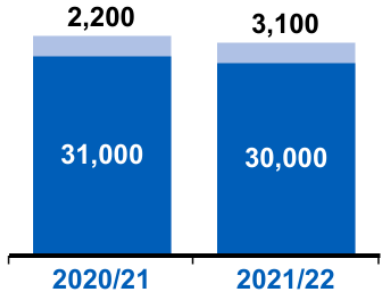
Key findings

33,000 total posts

30,000 filled posts

in the **local authority and independent sector.**

Change in **filled posts** and **vacancies**



There was a change of

-1,000 filled posts (-3%)

since 2020/21 in **local authority and independent sectors.**

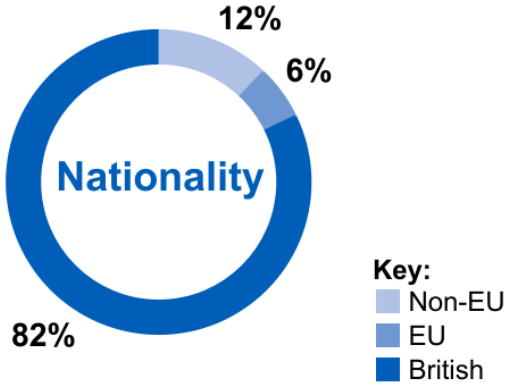
Average hourly pay for care workers

Local authority

£10.67

Independent sector

£9.48



32%

of filled posts were **zero-hours contracts**.

10.0%

average **vacancy rate** in 2021/22.

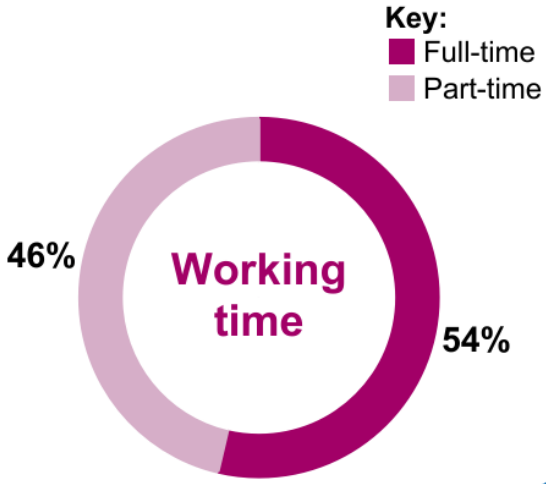
The average **turnover rate** was

29.3%

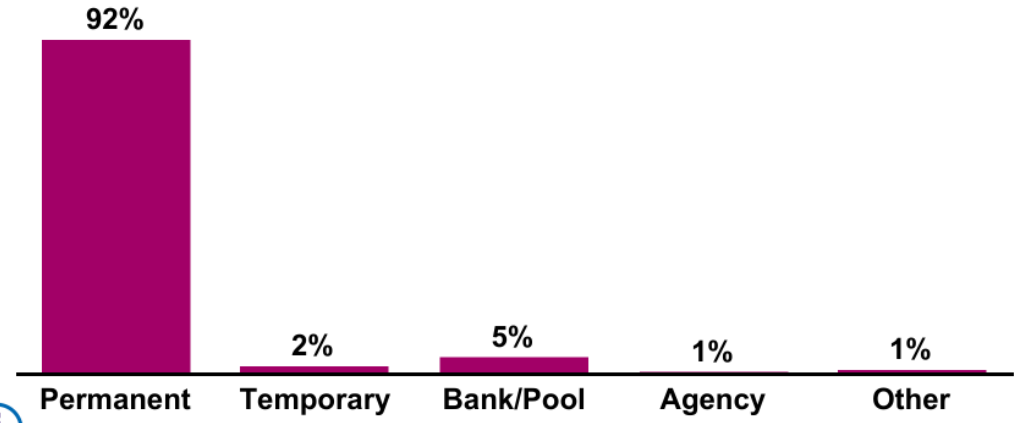
25%

were **aged 55 or above**.

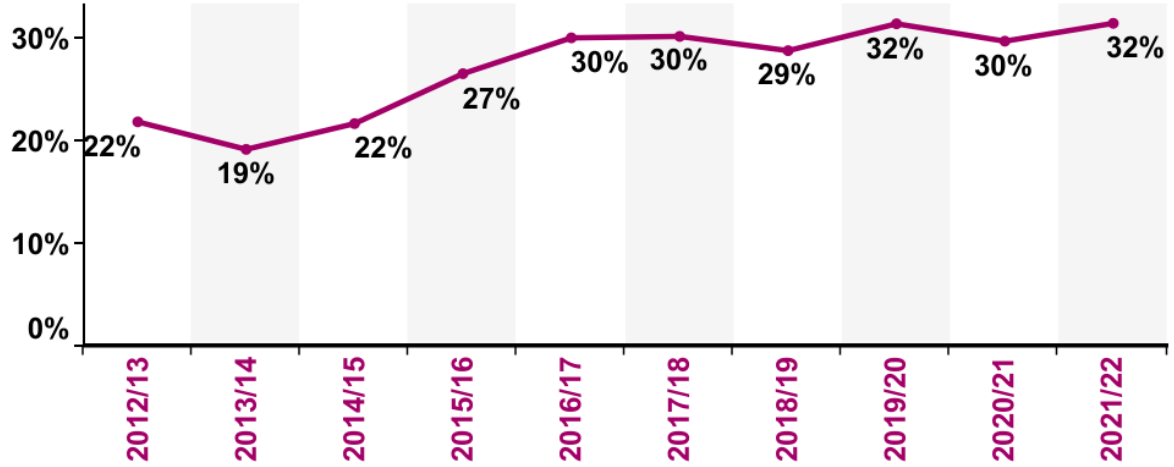
Employment overview



Employment status



Zero-hours contracts trends



Zero-hours contracts

32%

of filled posts were **zero-hours contracts** (or **9,400 filled posts**).

Recruitment and retention

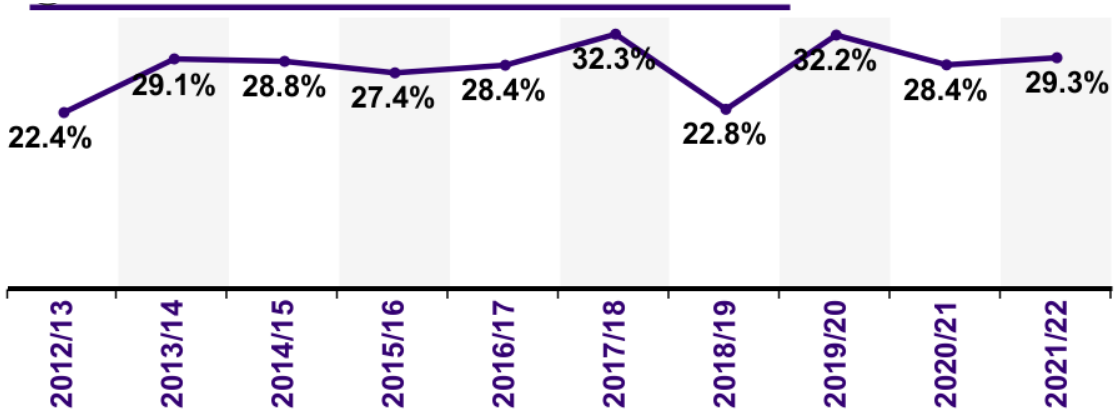
10.0%
vacancy rate (or 3,100 vacancies)
in 2021/22

29.3%
turnover rate (or 8,200 leavers)
in 2021/22

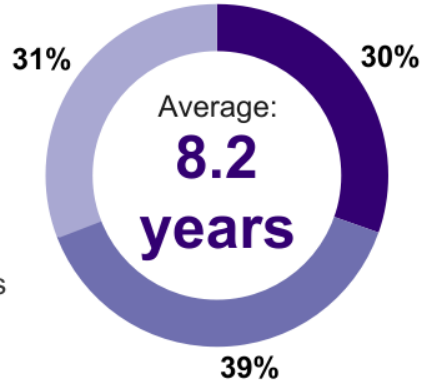
61%
of **recruitment** is from **within adult social care**

7.6
average **sickness days** taken in 2021/22

Turnover rates



Experience in sector



Key:
- Less than 3 years
- 3 to 9 years
- 10 years or more

Demographics

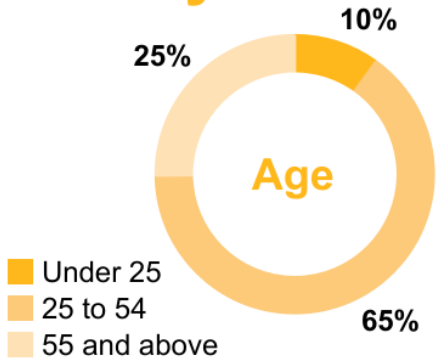
Gender

84%
of the workforce were **female**.

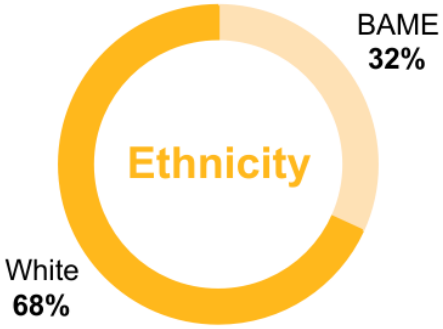
16%
of the workforce were **male**.

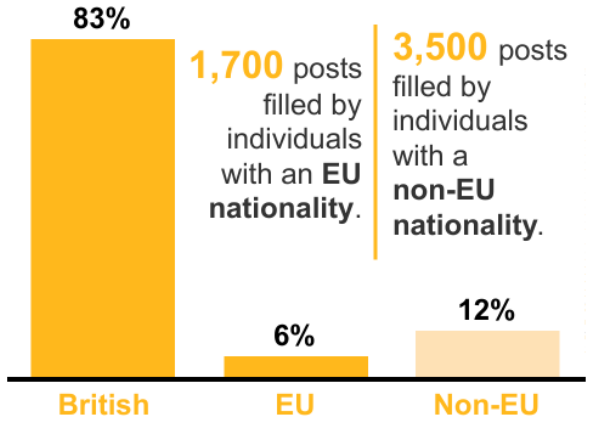
Age

The average **age** was
43 years old



Ethnicity and nationality

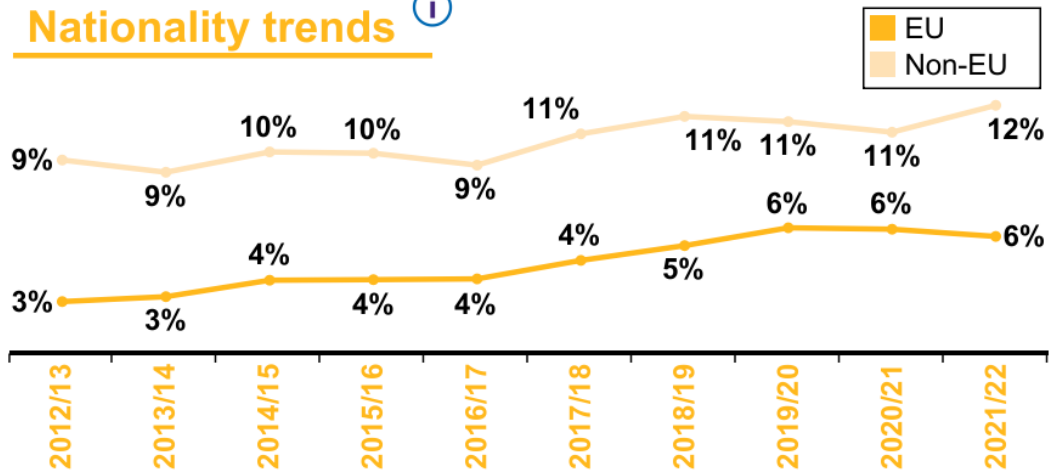




1,700 posts filled by individuals with an **EU nationality**.

3,500 posts filled by individuals with a **non-EU nationality**.

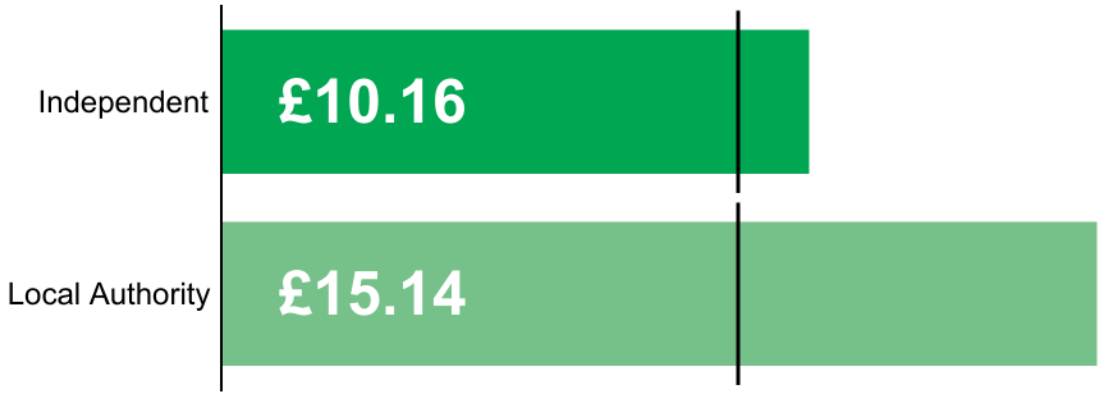
Nationality trends



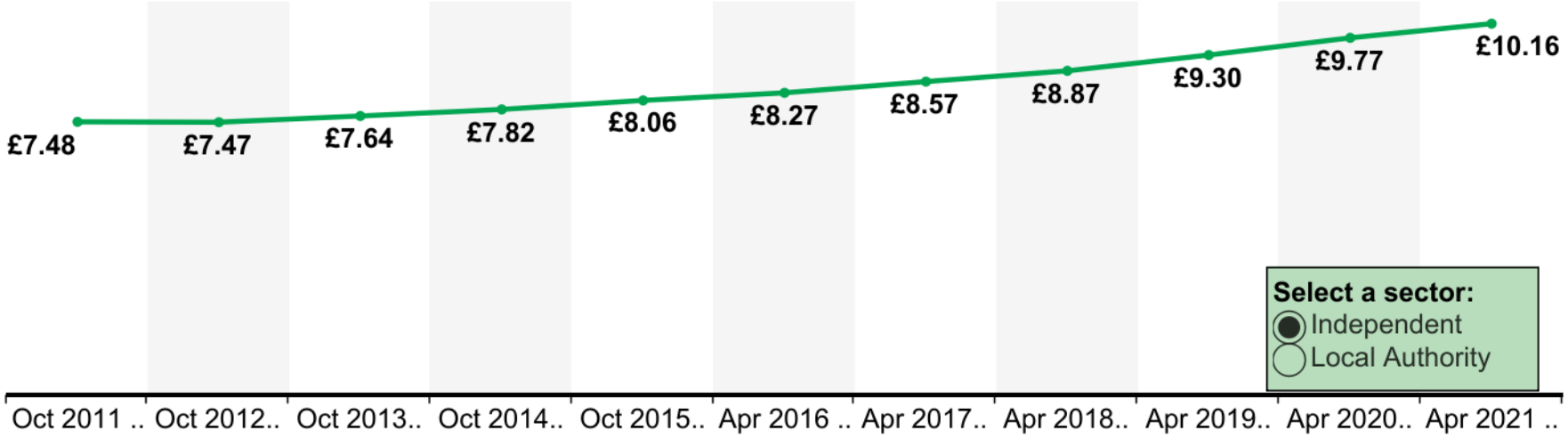
Pay

Mean hourly pay

The National Living Wage (April 2021 - March 2022) was £8.91



Mean hourly pay trends



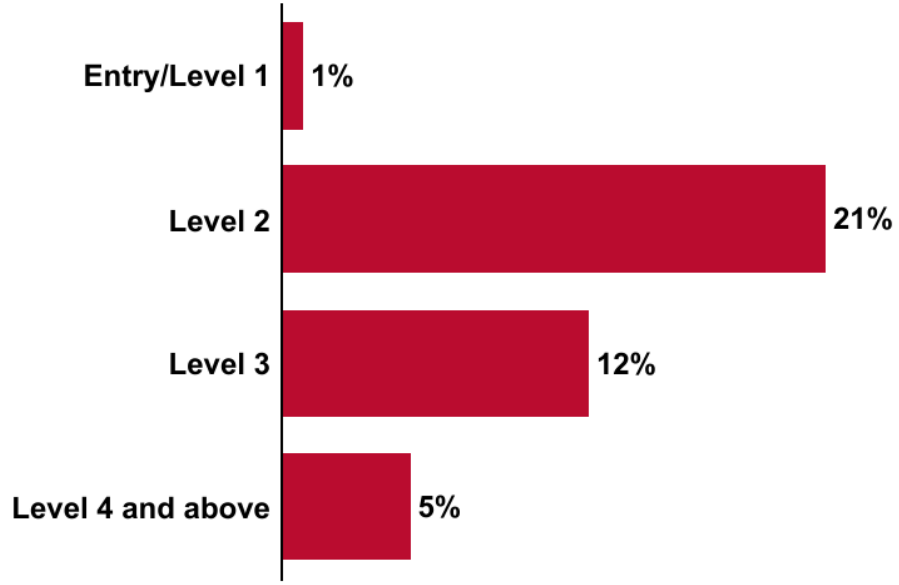
Qualifications and training

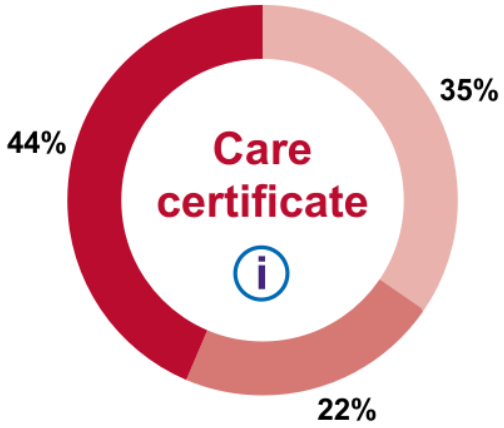
Please note that professional roles are not included in the data below because they must be qualified to perform their roles, e.g. social worker, registered nurse or occupational therapist.

38%

of workers held a qualification relevant to social care.

Qualifications by level



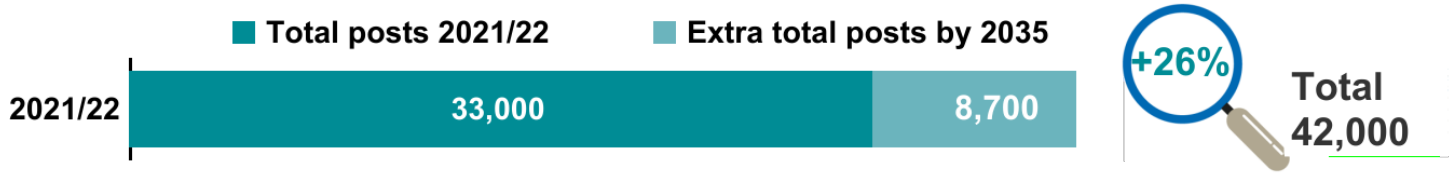


Key:

Complete
Not started
In progress /..

Workforce projections

This model projects the size of the workforce if it grows proportionally to the number of people aged 65 and over in the population. This workforce includes adult social care total posts employed by local authorities and the independent sector only. Posts employed by direct payment recipients and those in the NHS are not included.
Please note that demand due to replacing leavers will be in addition to the figures shown below.



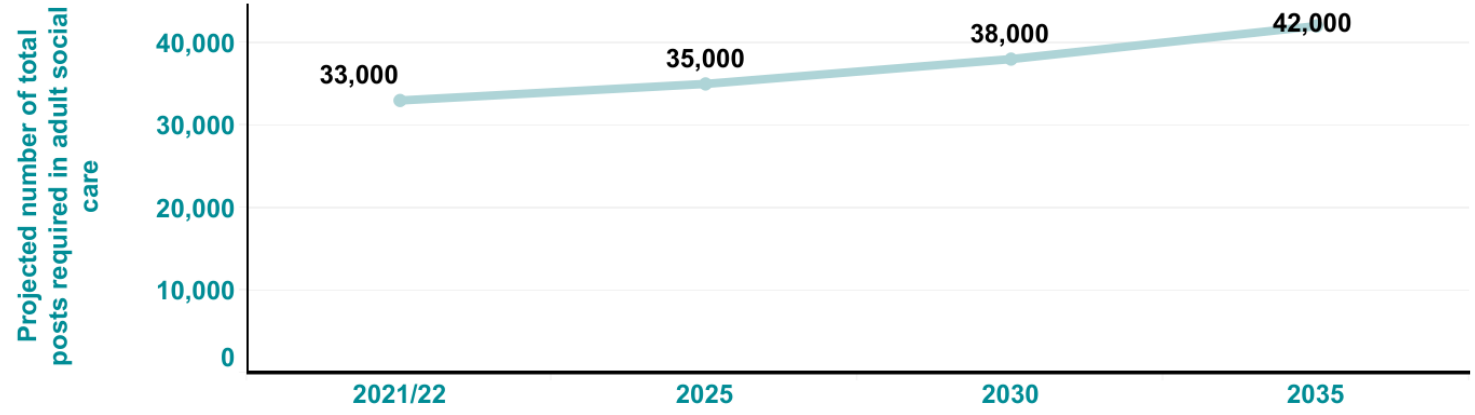
If the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population then the number of adult social care filled posts will...

increase by 26% (8,700 total posts)

...to around 42,000 total posts by 2035

...equal to around 700 extra total posts per year up to 2035

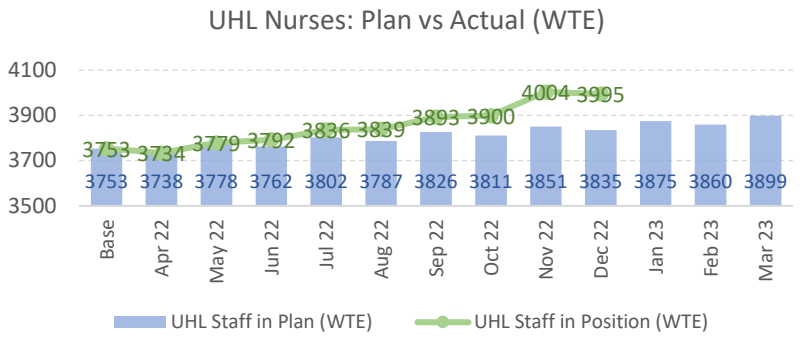
Projected number of total posts in adult social care required by 2035

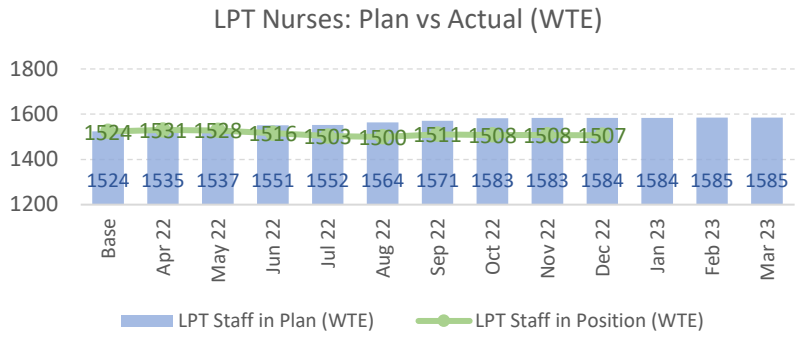


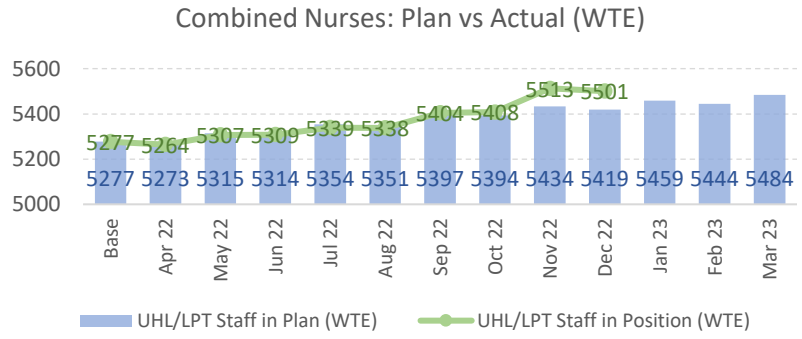
Additional Insight

Appendix

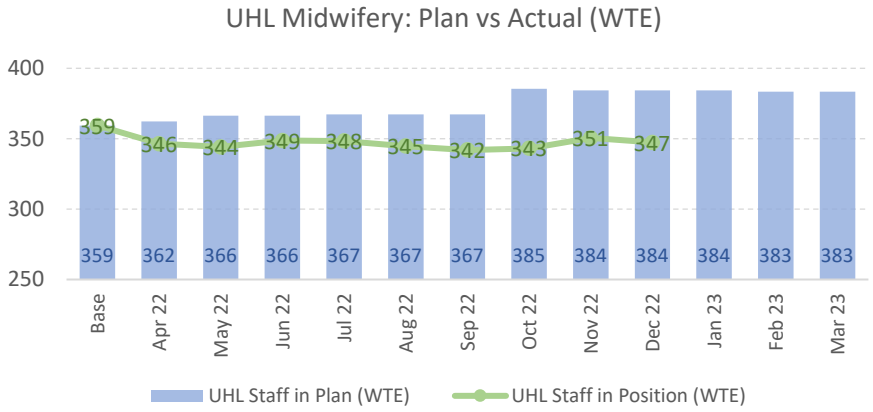
Nurse/Midwifery







Nursing is above plan in total across UHL & LPT. However this is due to UHL being substantially above plan while LPT have declined below March 22 position.

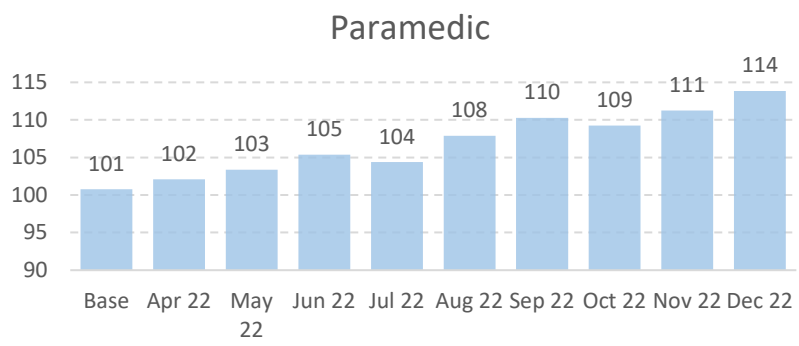


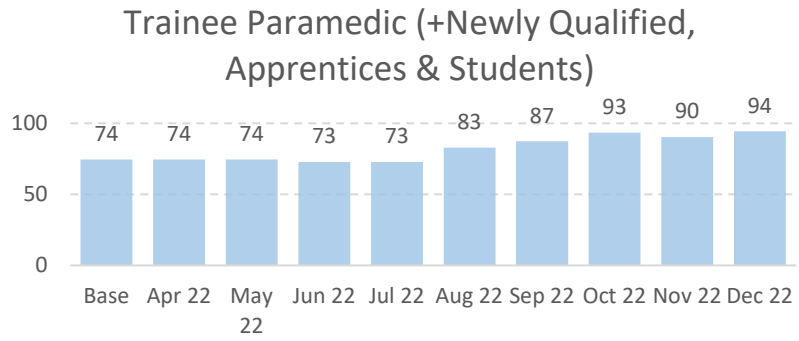
Midwifery has remained below base throughout 22 in UHL.

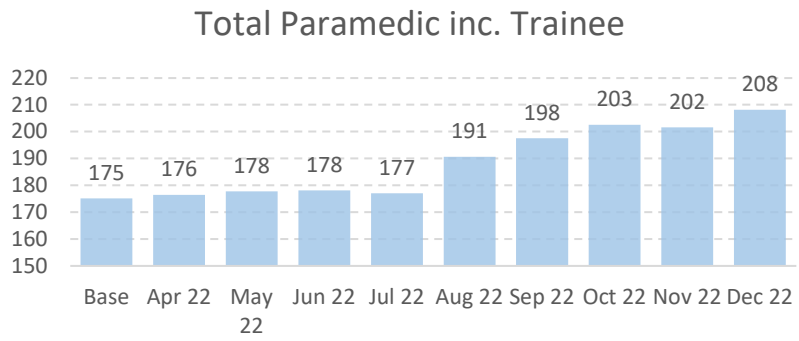
EMAS

EMAS Staff in Position (WTE)	Base	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22
Tatical Commander	12	12	12	12	12	12	12	11	11	11
Station Manager	6	6	6	6	6	6	7	7	7	8
Divisional Senior Clinical Leader	4	4	4	4	4	5	5	6	6	6
Specialist Practitioner	11	11	11	11	11	11	11	11	10	9
Emergency Care Practitioner	1	1	1	1	1	1	1	1	1	1
Paramedic	101	102	103	105	104	108	110	109	111	114
Trainee Para (+Newly Qualified, Apprentices & Students)	74	74	74	73	73	83	87	93	90	94
Technician	207	201	194	187	181	168	163	159	160	140
Trainee Technician (+Newly Qualified and Trainee)	23	23	23	22	22	21	14	14	10	23
Emergency Care Assistant	46	46	46	45	45	45	45	45	44	44
Ambulance Support Crew	11	11	11	11	14	13	13	17	17	22
Urgent Care Assistant	20	20	20	19	18	18	18	15	14	10
Total Paramedic inc. Trainee	**175**	**176**	**178**	**178**	**177**	**191**	**198**	**203**	**202**	**208**
Total	**517**	**511**	**505**	**495**	**490**	**490**	**485**	**488**	**480**	**482**
Total Growth (cumulative)		**-1.1%**	**-2.2%**	**-4.2%**	**-5.1%**	**-5.2%**	**-6.1%**	**-5.6%**	**-7.0%**	**-6.7%**

Paramedics and Trainee Paramedics have both shown consistent growth since March 22







J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**9 February 2023**	**Paper:**	**J**
Report title:	**Update on performance and delivery**		
Presented by:	Yasmin Sidyot, Deputy Chief Operating Officer, NHS LLR ICB		
Report author:	Yasmin Sidyot, Deputy Chief Operating Officer, NHS LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **NOTE** the development of the LLR System Delivery Group to oversee the delivery of performance and transformation across the ICB
- **RECEIVE for assurance** the briefing against delivery of the LLR winter plan and continued work to strengthen this
- **NOTE** the impact of the delivery of the LLR winter plan, on both the ambulance handover and the 104-week trajectories

Purpose and summary of the report:

This paper is in two parts; the first introduces a revised oversight framework for delivery of ICB objectives, designed to underpin delivery of the ICB vision, operational and transformational priorities.

The second provides assurance against delivery of the immediate ICB priority of a safe winter, covering improvements noted against key performance targets across the urgent and emergency care system and the elective recovery programme of work.

Appendices:	n/a
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Various iterations of this paper have been shared at organisational or system level meetings

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Risks relating to quality of care provided by acute and non-acute providers, including risks relating to emergency planning, resilience and response arrangements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No new funding requests Additional services referenced are funded via the Capacity Resilience Funding or Elective Recovery Funding
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The plans put in place through the winter plan has supported mitigation of patient safety and quality issues caused by both operational pressures and industrial action where possible
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Any new services / service changes will be made with due regard to the Inclusive Decision-Making Framework and the PSED

Briefing note: Performance and delivery

9 February 2023

Introduction

1. This paper is in two parts; the first introduces a revised oversight framework for delivery of ICB objectives, designed to underpin delivery of the ICB vision, operational and transformational priorities. The second provides assurance against delivery of the immediate ICB priority of a safe winter, covering impact against key performance targets across the urgent and emergency care system and the elective recovery programme of work.

Part One: Revised oversight framework

2. The ICB has committed to transforming the way we design, deliver and assure the care received by our LLR citizens and has identified a number of strategic priorities which align to national NHS England priorities. Together, these define our transformation programme.

3. Objectives have thus far been delivered through a mixture of informal 'design groups' and more formal 'collaboratives'. However, the ICB does not have one group with oversight of performance, delivery and transformation against the agreed objectives outlined in the ICB Operational Plan and longer-term strategies. This has led to a duplicative reporting system, with some collaboratives or design groups reporting into multiple groups on a monthly basis and some not reporting anywhere formally.

4. To strengthen oversight and delivery in every programme of work, a **system delivery group** has been proposed, with responsibility for driving the overall performance and delivery of our ICB commitments, giving equal focus to performance as well as transformation. By working as a system in this manner, this approach will also support cultural transition across system leadership and management; a 'system first' approach will be propagated actively encouraging collective problem solving and challenging practice to reduce duplication.

5. The key focus of the SDG will be to:

   a. To act as the key system forum for reviewing delivery against system-level one- and five-year performance trajectories and transformative plans, holding the Chief Operating Officers and Senior Responsible Officers/programme leads (where relevant) to account and receiving assurance on performance improvement by exception.
   b. To have oversight of performance & transformation related risks and issues that will impact upon delivery of 1 year or 5-year priorities. This includes identifying and presenting risks and issues at the meeting so that actions can be agreed, risks can be mitigated through an escalation approach via the LLR System Quality Group. It also includes the sharing of key issues and concerns raised by NHS England.
   c. To review and ensure plans and performance trajectories embed and work towards addressing health inequity and deliver better outcomes.
   d. To receive assurance on delivery but also participate in any deep dives or any associated audits as needed requested by the ICB Board or sub-committee.
   e. To work with NHS England in line with the NHS England/ICB Memorandum of Understanding, as part of an integrated approach to driving performance.
   f. To escalate areas of concern to the LLR System Executive/Clinical Executive as necessary following regular reviews of performance.

6. This will require a fresh operating culture to be implemented – one wholly appropriate for a developing ICB. Current thoughts for an operating culture include:

g. To act as a central system for creating a 'single version of the truth' on delivery against performance and transformational objectives, with the aim to reduce duplication via one single, agreed highlight report. This will enable information to be shared across the wider system, including providers and NHSE and for all to ensure a healthy level of support, confirm and challenge from the different key functions / enabling elements.
h. To embed and maintain collective and system responsibility for driving improvement and transformation against plans and trajectories, whilst facilitating and embedding the ICS principles of subsidiarity, innovation, value for money and system financial sustainability. This includes adopting a 'system first' approach over an individual organisational approach to improve performance for the system as a whole. In practice, this will involve discussions relating to mutual aid amongst system partners and others to drive system performance.
i. To provide constructive challenge and support to our Collaboratives by requesting and receiving assurances reports on recovery plans as needed and supporting escalations as required
j. To embrace, facilitate and support any improvement initiatives using international/national and local best practice in line with national policy and local priorities, working with NHS England as and when required to drive performance improvement.
k. Programme representatives to share documentation slides/presentational information on performance on a bi-weekly basis.

7. The SDG will work together with Senior Responsible Officers including the Chief Operating Officers (COOs) or Executive Directors of the key system partners for all programmes to gain assurance and to drive delivery and improvement. This will be implemented in an integrated way and will be aligned with national and local strategic priorities.

8. The LLR System Executive has agreed the ethos behind this group and mandated a sub-group to finalise the scope, operating model and supporting paperwork in readiness for an initial meeting in April 2023.

9. A formal assurance report will be presented to the LLR System Executive monthly and onwards to the public session of the ICB as appropriate.

Part two: Delivering a safe winter

10. This section provides an overview of the LLR health and care system over Q3 22/23 and into Q4, including responses to extra-ordinary events such as the ambulance service industrial action, Leicester Hospitals' critical incident, and overall management of operational pressures across all parts of health and care.

11. Whilst patient safety has been maintained as best possible, it is recognised that the patient experience of care remains sub-optimal across services. Staff are equally reporting high levels of moral injury, particularly those in frontline acute services within EMAS and the Emergency Department.

12. Performance against the LLR Winter Plan has been positive, with the majority of schemes delivering at 75-100% of expected impact. One notable exception has been that of virtual wards; this has been slower to evidence impact in some pathways, despite all partners committed to delivery of the programme. A recovery plan has been agreed and is in the process of being enacted across LLR, with full clinical ownership. Due to this, zero impact has been factored in across Q3.

13. Evidence of the impact of the winter plan thus far is most notably evident against the ambulance handover trajectory. The challenge to systems was to achieve a 30-minute

average clinical handover time and as noted in the graph below, the LLR system is much closer to this trajectory than before:

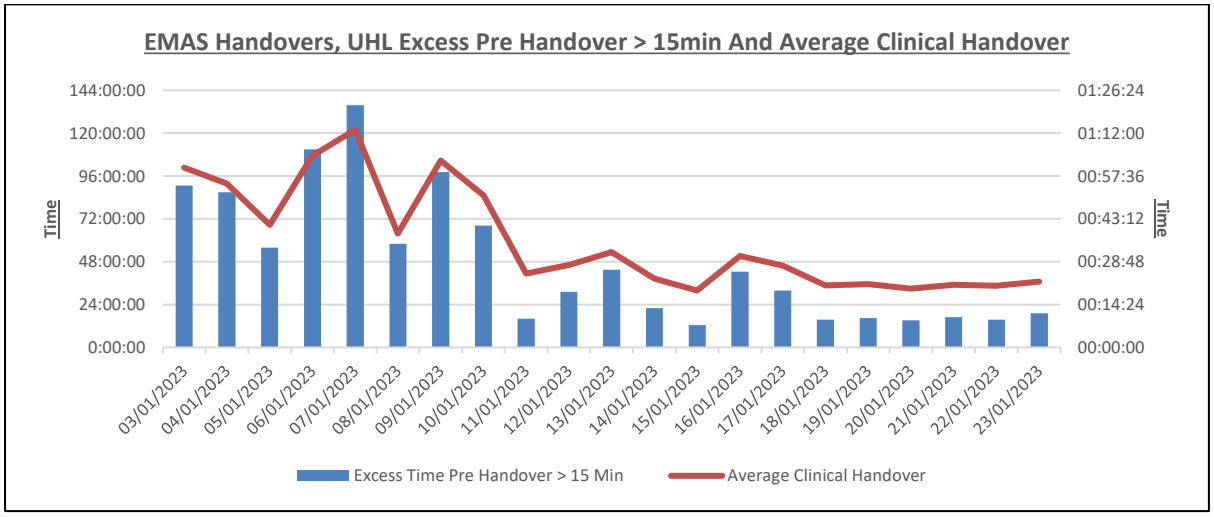


Figure 1: Average clinical handover times, Jan 2023

14. For the month of January, the average clinical handover time (1st Jan to Jan 29th) stood at 35 mins and 42 seconds. As a comparison, the average clinical handover time in Q3 22/23 stood 1hr 18mins and 52 seconds.

15. Whilst this is positive movement, it should be recognised that the additional capacity opened to support flow into and out of the Emergency Department has increased pressure across the whole pathway. In recognition of this, the winter plan has been further strengthened to ensure this trend can be maintained through the next modelled peak in demand, predicted for mid-February 2023 onwards.

16. A quality improvement methodology has been employed through this winter and supporting winter plan schemes are now also evidencing successful impact, both in terms of input and outcomes:

a. The streaming service from the Emergency Department to local urgent treatment centres has been particularly successful, diverting upwards of 50 patients per day into more appropriate services with closed episodes of care. This has in turn reduced overcrowding within the Emergency Department, without causing pressure on partner services such as general practice.
b. The cohorting areas for handover have been successfully integrated as part of the emergency pathway at UHL, releasing ambulances in a timely manner to respond to emergencies in the community. As a result, mean cat 2 response times have been met since early January 2023.
c. The unscheduled care hub continues to provide holistic health and care to appropriate patients awaiting an ambulance response. Again, between 20 and 40patients a day are streamed to alternative services; these integrated services are not only dealing with the presenting condition but also taking the opportunity to support the patient for future risk management i.e. fuel poverty, assistive technology etc.
d. Time to discharge continues to fall with complex discharge now taking place faster and more importantly, with patients being discharged onto the correct pathway for their needs, supporting longer term reablement outcomes. The traditional annual Dec-Jan peak in medically optimised for discharge patients has not been seen through Dec and Jan, with the numbers of medically fit patients remaining within normal variation.

e. The pathway for mental health has also been strengthened for winter, with additional signposting, support and service provision in place. This has resulted in fewer patients within the emergency department itself and more patients referred to other services as appropriate.

17. Improvement has also been noted across the elective care pathway. Whilst the challenge remains significant there is continued good progress on the reduction of those patients waiting longest for definitive treatment.

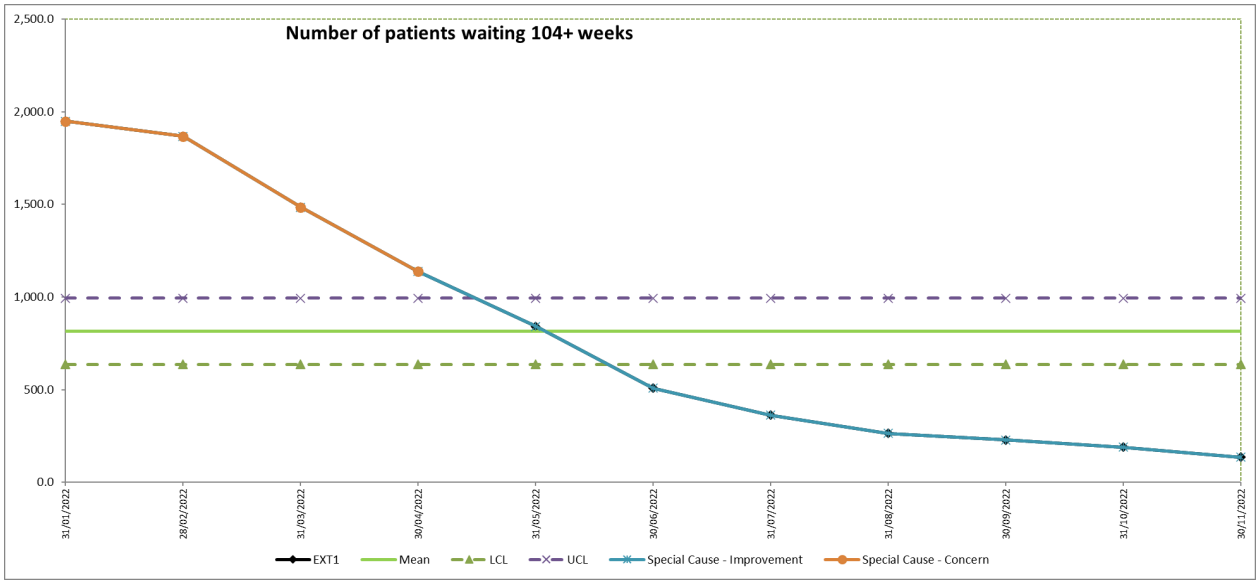


Figure 2: 104-week trajectory

18. However, significant risk remains on the admitted 104 position due to an increase in cancellations due to emergency pressures in some areas; this has been most acute amongst paediatrics. Despite this, whilst on the day cancellations are usually high during Dec and January, this winter the system has seen less on the day cancellations than in previous years.

19. The total cohort of patients waiting 104 weeks or more until end of March 2023 is 478. However, 46% of these patients have a next step booked BEFORE the end of March. The system is on track to deliver the forecast trajectory for January 2023 – 78 patients for UHL and 94 across LLR.

20. There remains in place patient level senior oversight of the total cohort to ensure no avoidable breaches occur. In addition, weekly calls are in place with the UHL CEO/COO/Dep COO and System Director to ensure oversight of delivery.

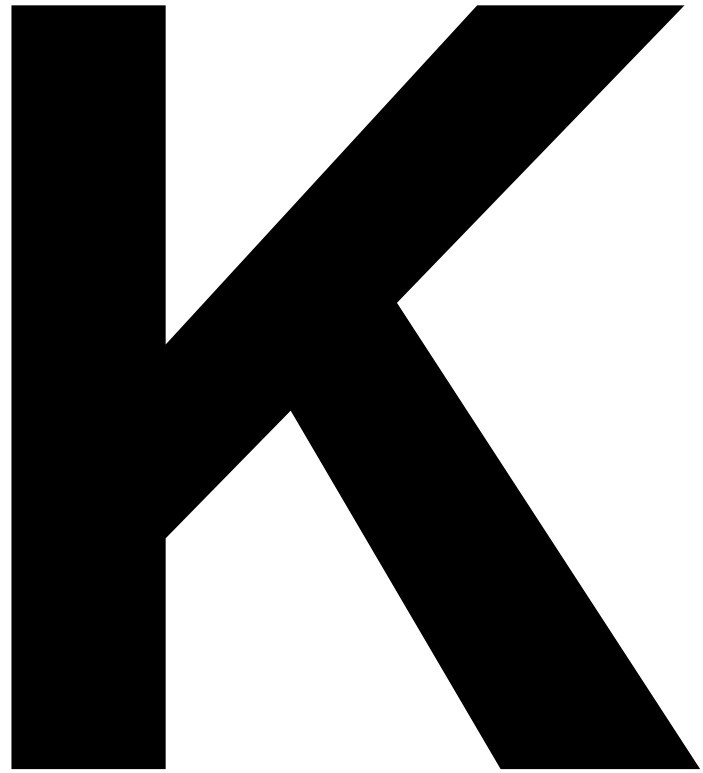
Conclusions

21. Delivery against ICB operational and transformational objectives remains a key priority for the LLR system. The development of an LLR System Delivery Group will support delivery of the LLR ICB vision and underlying objectives, including against those focussed on increasing equity of access and outcomes. This will also support appropriate escalation to formal ICB sub-committees.
22. Operationally, the LLR system remains under significant pressure, with a further peak expected in mid-February 2023. Despite the challenges, the LLR system has continued to improve against two key ICB performance trajectories – the ambulance handover and the 104-week trajectories. Work continues to strengthen this plan over the coming weeks and in readiness for winter 2023/24.

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **NOTE** the development of the LLR System Delivery Group to oversee the delivery of performance and transformation across the ICB
- **RECEIVE for assurance** the briefing against delivery of the LLR winter plan and continued work to strengthen this
- **NOTE** the impact of the delivery of the LLR winter plan, on both the ambulance handover and the 104-week trajectories



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**9 February 2023**	**Paper:**	**K**
Report title:	**Finance Report Month 9 2022/23**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of Finance (System).		
Executive Sponsor:	Caroline Gregory, Chief Finance Officer		

To approve ☐	**For assurance** ☐	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** the financial position as at month 9 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) system position is a deficit of £15.7m.

UHL have reported a YTD deficit of £11.3m, LPT have reported a YTD deficit of £2.5m, whilst the ICB have reported a £1.9m YTD deficit.

The system has declared a deficit forecast of £20m (UHL £17.7m deficit, LPT £2.9m deficit and ICB £0.6m surplus) as agreed with organisational Boards and NHSE.

Appendices:	• Appendix 1
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• CFO • Finance Committee • System Execs

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒

5. NHS Constitution	Deliver NHS Constitutional requirements.	☐
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☐

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		This aligns to the financial sustainability risk
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Yes as the report focuses on the financial position
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		

Finance Report Month 9 2022/23

9 February 2023

Month 9 System Financial Position

1. Dashboard:
   The system dashboard is shown below:

System	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	(5,470)	(15,745)		-	(19,976)	
System Revenue expenditure not to exceed income	1,991,033	2,006,778		2,651,389	2,671,366	
System Capital expenditure not to exceed allocations	54,100	46,634		97,358	97,358	
System Operates within Cash Reserves	88,537	113,857		105,344	93,220	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	15,422	13,596		20,518	18,507	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	138,793	141,445		189,750	191,335	
CIP delivery	43,534	46,154		70,730	63,012	
Better Payment Practice code % NHS invoices paid within target (£)	95%	95%		95%	95%	
Better Payment Practice code % NHS invoices paid within target (number)	95%	89%		95%	89%	
Agency spend within ceiling				43,500	57,465	
ICB MHIS spend requirement to meet target				172,694	172,778	
Performance against ERF Allocation	30,411	28,729		39,983	40,339	
COVID Year on Year Comparison	12,972	3,344		19,962	4,019	

Revenue

2. **The system is reporting a year-to-date deficit of £15.7m which is £10.3m worse than plan**, (UHL £6.7m adverse variance, LPT £1.7m adverse variance, ICB £1.9m adverse variance against plan). The position reflects pressures relating to emergency care, sustained high mental health acuity, agency costs, out of area activity and growth in CHC packages.

3. **The system is forecasting a £20m deficit year end position**, UHL are reporting a £17.2m year-end deficit, LPT a £2.9m deficit and ICB a 0.6m surplus. The system is on track to deliver the £20m deficit control total. The year-end target has now formally changed following discussions with organisational Boards and NHSE from break even to a deficit of £20m.

4. The system has planned **efficiencies** of £70.7m of which we are currently forecasting £63m delivery (£46.2m achieved year to date). System-wide cost avoidance and income generation plans totalling £26.4m were identified at the planning stage but were not included in

organisational plans as efficiencies (rather they were included as expenditure reductions); we have only identified limited savings of £5m against these to date.

Capital

5. Capital spend is currently below plan by £7.5m with a year to date actual spend of £46.6m. The system is forecasting break even spend against its operational capital of £58.7m, and against the additional £38.7m capital funding received from national programmes.

Other Indicators of note

6. **Agency spend** remains above target. The position has been impacted the use of a surge ward at LPT staffed predominantly by agency.

7. **Better Payments Policy** expectation across all public sector organisations is to pay creditors in a timely manner. LPT and ICB are achieving the cumulative standard of 95% of invoices (both in value and volume) paid within 30 days, UHL is cumulatively at 70% in relation to the numbers of NHS invoices paid within 30 days (non-NHS at 93%).

8. NHS partners within LLR are expected to manage their **cash** position proactively in line with plans and cash draw down limits. The current financial deficit position will impact on cash usage across all partners. There is no system for transferring cash between partners without the raising of invoices. UHL and LPT are currently holding above plan cash balances with the expectation that these will reduce slightly over the remaining months of the year. The ICB is maintaining a minimal end of month cash balance as required.

9. The ICB receives funding for specific elements of spend within its allocation. Better Care Fund, Primary Care Co-Commissioning, Mental Health Investment and running costs are examples of these. The ICB has committed funds in line with allocations in all these areas and is forecasting to spend more in relation to Primary Care Co-commissioning and Mental Health Investment but to underspend against its running costs

10. **Primary Care Co-Commissioning** is forecasting an overspend of £1.6m against the allocation for 22/23.

Conclusion

11. As a system at month 9, we have reported an in-year deficit of £15.7m against revenue budgets and forecast a £20m year-end deficit.

12. Capital spend is currently below plan and forecasting a breakeven position.

13. We are declaring achievement of the mental health investment standard, better payment practice code and running costs targets.

14. Cash position is below plan but remains positive across the system.

Recommendations:
The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** the financial position as at month 9 and the forecast performance
- **RECEIVE for assurance.**

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	9 February 2023	**Paper:**	**L**
Report title:	**Assurance Report from the ICB Finance Committee**		
Presented by:	Cathy Ellis – Chair of ICB Finance Committee		
Report author:	Cathy Ellis – Chair of ICB Finance Committee Imran Asif – Corporate Governance Officer, LLR ICB		
Sponsor:	Caroline Gregory – Interim Chief Finance Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Finance Committee meeting held on 20 December 2022 and 25 January 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.
2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
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6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The focus is on the current and projected financial delivery for 2022/23 and for the 5 year medium term plan. There are risks associated with both forecasts. .
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		There are risks to delivering a statutory break even in 2022/23. A revised control total of £20m deficit has been agreed for the system.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however, the principles are contained with the Constitution and governance arrangements.

Assurance Report from the ICB Finance Committee

1.0 Introduction

1.1 This report provides a summary of the key areas of discussion and outcomes from the ICB Finance Committee held on 20 December 2022 and 25 January 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

2.0 Financial Outturn 2022/23 and Month 09 system revenue and capital position

2.1 NHSE issued a national protocol in November 2022 which must be followed if systems cannot deliver a break-even outturn. The criteria have been fully assessed by organisations. ICS system partners have reviewed the requirements together and the Finance Committee were provided with a RAG rating against each of the criteria. The Committee asked for further evidence of the workforce bridge and variance analysis to be circulated. The ICB subsequently reported at the ICB meeting on the 12 January that all criteria were RAG rated Green.

2.2 The system has agreed a control total of £20m deficit with NHSE. Forecast year end positions were reported for each organisation, LPT £2.9m deficit, UHL £17.7m deficit and ICB £0.6m surplus.

2.3 Committee discussion focused on the month 10, 11 and 12 run rates to achieve the financial outturn control total. LPT and UHL were able to provide assurance on the stability of their run rates at month 09. LPT had a consistent run rate for months 08 and 09 and had its lowest spend on agency in month 09. UHL shared the operational risks for urgent and emergency care that could have an impact on the financial outturn. There was proactive management of expenditure within UHL and control totals had been agreed with Clinical Management Groups.

2.4 UHL and LPT expressed that they were confident in managing the Capital budget, despite significant expenditure to be committed in the remaining three months of the year (UHL have £42.2m to spend, this is being managed via a rigorous allocations process and trajectories are closely monitored; and LPT have £8.5m to spend and have been able to pull forward previously deferred schemes).

2.5 In December, the Finance Committee considered three options for the risk share arrangements and the potential impact.

- Option 1 – Leaving the current recovery plan targets issued as they are
- Option 2 – Redistribute the revised deficit on the risk share %
- Option 3 – Sit the deficit with one ‘type’ of organisation.

2.6 The Committee recommended the decision be taken by the System Executive meeting on 23 December. Subsequent discussions with the ICB, LPT and UHL Chief Finance Officers identified that criteria for enacting the risk share had not been followed and on that basis it was recommended that deficits remain within respective organisations. This was endorsed by System Executive.

3.0 Sustainability Audit Report

3.1 The LLR system partners have completed the HMFA Financial Sustainability Self-Assessment.

3.2 Internal Audit have reviewed the results and provided recommendations to ensure improvements are embedded within the LLR system.

3.3 The internal audit reports have been presented to each system partner's Audit Committee. LLR organisations are developing action plans with SMART actions. Internal audit will confirm completion of action plans through monitoring and will report back to Audit Committees.

4.0 2023/24 Financial Planning – Revenue and Capital

4.1 The Finance Committee were briefed on the 2023/34 planning process. The draft plan will come to the 22 February meeting. It was noted that there is a sizeable financial challenge and high expectations regarding ability of the system to support existing cost pressures and new investments. To help prioritise need it was agreed that the system needed to focus on 4 key areas: -

- Achieving the 31 national must dos
- Statutory requirements
- Opportunities for invest to save schemes which are cash releasing in year; and
- Patient safety.

4.2 The Committee discussed the underlying system position in 2022/23 and how this would be reconciled to the 2023/24 as part of the roll forward of the current baseline. A waterfall chart was requested to highlight the significant movements.

5.0 Transformation and Efficiency Schemes

5.1 There remains significant risk across transformation schemes with an underachievement reported of £29.4m against the annual target of £97.1m. A further 140 schemes have been requested for investment totalling £122m in 2023/24.

5.2 Discussion focused on the need to have a robust planning process that ensures financial, clinical and health equity priorities are considered. The Committee noted that there is likely to be little funding available for investment, so an efficient review process needed to be undertaken.

5.3 The Committee encouraged a multi-year planning approach. A wider discussion took place around the current approach which builds on existing services rather than explore the whole. There was a recommendation for the LLR system to move away from this and consider a new business model for 2024/2025 and beyond.

6.0 Finance Report on the Delegation of NHSE directly commissioned services for 2023/2024

6.1 An update was provided that the Pharmacy, Optometry and Dentistry (POD) delegated budgets that will be allocated to the LLR system in April 2023 by NHSE.

6.2 Specialised commissioning will be delegated in April 2024.

6.3 A paper will be presented to the finance committee in month 10 to give further assurance on the POD budget. NHSE have provided assurance that there will be no financial gaps in the budget allocated.

7.0 Month 09 Risk Register

7.1 The month 09 risk register has been restructured into two sections: strategic risks that impact 2022/2023 and those which have a medium-term effect. The Committee felt that three risks relating to urgent care, workforce and elective recovery were all significant drivers for cost, so should be retained with oversight at the Finance Committee.

7.2 The connection of Committee risks to the ICB Board Assurance Framework (BAF) was discussed at the ICB development session in January 2023. The draft ICB BAF has one financial risk "Financial sustainability – failure to establish a shared culture of financial stewardship to ensure financial sustainability across the system".

7.4 The Finance Committee will be aligning the seven existing financial risks to the ICB BAF.

7.5 There was a request to ensure key milestone actions were added to the actions section of each risk in the risk register.

9.0 Committee Work Programme

9.1 The committee work programme was reviewed and will be updated for 2023/24 planning deadlines.

10.0 Summary of assurance from the Committee

10.1 The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. 2022/23 Financial Outturn and Month 09 System revenue and capital position	**Amber**	The LLR system has agreed a deficit of £20m, run rates have stabilised however UHL identified potential operational risks to urgent and emergency care.	Risk that £20m deficit could be exceeded.
2. Sustainability Audit Report	**Green**	LLR organisations have completed the audit and are developing actions to address highlighted improvement areas. Assurance on delivery of actions will flow through Audit Committees in Q4.	
3. 23/24 Financial Planning – Revenue and Capital	**Red**	Draft planning guidance for 2023/2024 has been released, the LLR system are working on producing a draft financial plan which will be shared with the Committee on 22 February and submitted to NHSE on 23 February 2023.	Underlying deficit position could reduce opportunity for investment
4. Transformation and Efficiency Schemes	**Red**	Significant shortfall remains for transformation schemes.	Failure to transform will not address the underlying deficit
5. Finance Report on the Delegation of NHSE directly commissioned	**N/A not rated**	LLR to be delegated POD budget in April 2023. Finance Committee to receive a paper in M10 with further details.	

	services for 2023/2024			
6.	**Month 8/9 Risk Register**	**N/A not rated**	Month 9 risk register has been redesigned to include two sections on strategic risks impacting on 2022/2023 and strategic risks that have a medium-term effect.	

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	9 February 2023	**Paper:**	**M**
Report title:	**Assurance Report from the System Executive**		
Presented by:	Andy Williams, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Sponsor:	Andy Williams, Chief Executive LLR ICB and Chair of the System Executive		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meetings of the System Executive Committee held on 23 December 2022 and 27 January 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed in paragraph 18.

Appendices:	• Appendix 1 – System performance assurance report as presented to the System Executive
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒

6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The focus is on mitigating strategic risks as identified in the BAF and to identify and evaluate risks on an ongoing basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Assurances received in relation to the financial plan.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however due regard is considered within reports presented to the Committee.

Assurance Report from the System Executive

Introduction

1. This report aims to provide assurance to the Board and a summary of the key updates, decisions, and outcomes, aligned to the Committee's delegated authority, following meetings of the System Executive Committee held on 23 December 2022 and 27 January 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Strategy and planning

2. The Committee was assured that the **Operational Plan 2023/24** continues to be considered and national planning guidance has now been released. Limited staff capacity has been identified as a key risk to planning.

3. The *Birmingham and Solihull (BSOL) Integrated Care System (ICS): System Prioritisation Framework* was explored as a framework that could be used as the LLR ICB investment and disinvestment framework from January 2023. The Committee noted support from the Clinical Executive Group to use this Framework ensuring that an assessment of clinical risk is incorporated into the process.

4. The Committee will continue to monitor progress with the operational plan and also consider it in the context of the longer-term planning process and priorities.

Operational performance assurance

5. The **financial position at month 9 (December 2022)** identified that the system year to date (YTD) deficit has deteriorated by £1.4m since that reported at month 8. An updated position will be reported to the Board under a separate agenda item.

6. **The LLR system performance report** is considered as a standing item at every meeting. The report in December covered a selection of key performance indicators as follows with benchmarking intelligence and local actions outlined:

    - Urgent Care including 6 winter plan metrics and ambulance handovers
    - Primary Care
    - Elective Waits: 52-, 78- and 104-week waiters
    - Cancer
    - Learning Disabilities
    - Maternity
    - NHS Oversight Framework Quartiles.

7. The Committee specifically drew out the data relating to learning disability health checks noting that a spike in performance usually occurs in quarter 4. However, the data captured in the local learning disability health check dashboard, which is currently being piloted, shows that local performance is on trajectory. It was agreed that this local intelligence should be reflected in the performance reports going forward to provide a broader perspective on performance.

8. Pressures in demand and performance across the Urgent and Emergency Care pathway were highlighted. Improvements have been recorded in ambulance handover times however significant bed waits remain. Preparations for 2023/24 and how learning is being used to inform both one-year and five-year plans across LLR were considered.

9. The detailed system performance report for January as presented to the Committee is appended for information at **Appendix 1.** The content aligns with the requirements as set out in NHS England's Oversight Framework.

10. **Elective Care Update: RTT / Diagnostics/ Cancer** – the Committee considered progress on elective care recovery, including continued action being taken to mitigate risks. Challenges remain for specialties including urology, lower GI and skin. The Committee noted that a system cancer summit meeting was to be held in the coming months.

11. **H2 re-set update – a specific update on workforce and winter was provided.** The Committee reviewed for oversight and assurance the LLR Workforce Dashboard in December, acknowledging that a detailed review is undertaken at the People and Culture Board on a monthly basis. The Committee were able to ascertain the workforce need, and the associated actions being taken.

12. The Winter Plan for LLR had previously been agreed in readiness for the winter months, with twenty priority actions agreed in collaboration across health and care. Notwithstanding the mitigations in place, the Committee acknowledged that additional factors have impacted on the scale of demand resulting in a residual gap in beds across the system. The importance of ensuring that patients are in the right place at the right time was emphasised. Further work is therefore underway to strengthen the plan, including opening further capacity and exploration of more transformational change is being tested with partners to support flow of patients across the system.

13. The Board will receive a separate report and overview of the performance and progress made in relation to the Winter Plan including a proposal to establish a performance and delivery group.

14. The Committee considered **the establishment of two sub-groups: the System Delivery Group and the System Strategic Planning Group** to support in the discharge of its functions. The Strategic Delivery Group is to coordinate the delivery of functions across the system with a focus on the strategic development of the ICB. The System Strategic Planning Group will ensure that strategic development is aligned across the system with a focus on the delivery of strategic plans. The draft terms of reference for each Group are to be developed and considered at a future meeting.

15. **Children and Young People's (CYP) Design Group - System Quality Group Update November 2022 –** the update on the work of the CYP Design Group enabled the Committee to consider some of the challenges and risks aligned to this workstream, including prioritisation through the planning and commissioning processes and quality and safety risks. It was agreed that further consideration by the Quality and Safety Committee or the System Quality Group would be helpful to evaluate the impact of the risks and to determine the appropriate action to be taken.

Other decisions including business cases, procurements and contracts

16. Committee members considered and supported a number of decisions as follows all of which fall within the delegated authority of the Committee:

    a. **VCS Getting Help in Neighbourhoods (GHiN) Mental Health Grant Scheme – Round 2 – Confirmation of successful organisations individual awards –** approval was granted to notify the 26 organisations who successfully met the criteria of the fund.

b. **Step 3.5 Psychological Therapy Pathway** was approved in response to risks raised in Quarter 2 of 2022. This additional step within the pathway will positively impact individuals who are not currently in receipt of the correct service and will support flow through the Improving Access to Psychological Therapies (IAPT) pathway.

c. **Investment and Impact Fund (IIF) – Cancer Indicator Pathway Current Position and Proposal for PCNs for 2022/23 –** the use of the East Midlands Cancer Alliance funding to pay PCNs 50% of their total IIF opportunity was approved.

d. Direct contract award to **Trent Cliff (Independent Sector Capacity Framework) non-recurrent contract to support Elective backlogs funded by the Elective Recovery Fund 22/23** was approved to provide additional support and capacity to UHL within the Bariatric, General Surgery and Urology specialties on a non-recurrent basis for 2022/23.

e. **Forward planner** – the draft committee forward planner was received for comments ahead of final approval at the next meeting.

f. **Agreement for recruitment to Digital Innovation and Transformation Team (DITT) for ICS** – the Committee supported the proposal for further review and consideration of the funding by the Chief Finance Officers.

g. **Community Eye Care Service options – Interim proposal** – the use of elective recovery fund underspend to implement the Leicester Urgent Eyecare Scheme as an interim bridging service was approved.

h. **Direct award to DHU for Urgent Care Services at – Oadby, Loughborough Urgent Care (LUCC) and Merlyn Vaz (MV) and GP OOH Service (MV) till 31 December 2024** – a direct contract award was approved for the urgent treatment centre (UTC) service contracts at Oadby and Loughborough Urgent Care Centres, Merlyn Vaz, and GP out of hours services at Merlyn Vaz from April 2023 to December 2024 to Derbyshire Health United CIC (DHU) whilst the broader LLR UTC strategy is developed and enacted.

Assurance from sub-groups

17. Regular assurance reports are received from the Strategic Commissioning Group (group with delegated authority from the Board for primary care commissioning) and the Clinical Executive Group.

Summary of assurance from the Committee

18. The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Strategy and planning	**Amber**	• Positive progress being made and assurance received in relation to completion of the ICB's operational plan. However, risk has been highlighted in relation to staff capacity.	N/A
2. Operational performance assurance	**Red**	• The financial plan continues to present a challenge, mitigations are in place. • The System performance report – elective recovery continues in line with	Risks associated with the delivery of the winter plan, the financial plans and

		agreed plan, challenges remain across urgent and emergency care.	urgent and emergency care.
3. Other decisions including business cases, procurements and contracts	**Green**	• No specific issues identified.	N/A
4. Assurance from sub-groups	**Green**	• Reports are regularly received, and issues and risks identified along with mitigations.	N/A
5. Governance arrangements	**Amber**	• Terms of reference in place. • Committee forward planner is in draft once completed and approved the status will change to “green”.	N/A

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS
Leicester, Leicestershire and Rutland

NHS
Midlands and Lancashire
Commissioning Support Unit

LLR ICB SYSTEM EXECUTIVE COMMITTEE
Performance Overview

27th January 2023

Hannah Hutchinson– Assistant Director of Performance & Quality Improvement, LLR ICB

PERFORMANCE OVERVIEW

Key metrics for the LLR system

The aim of this PowerPoint is to provide details on the latest available position for each metric within the 2022/23 NHS Oversight Framework https://www.england.nhs.uk/nhs-oversight-framework/

Other performance metrics, listed below which are routinely reported have also been included:

- Ambulance Handovers,
- Six Winter Plan Urgent Care Metrics,
- Discharges,
- Elective long waiters,
- Cancer,
- Learning Disabilities & Autism,
- Primary care,
- LLR performance of the System Oversight Framework 22/23.

Improvements in LLR (1)

ACUTE CARE:

- **EMAS** mean 999 call answering time met target (winter metric)
- Number of patients **waiting for a bed in ED** at 8am reduced in January compared to December
- **2 hour urgent response** activity above threshold

HOMEFIRST:

- Improvement compared to last year in proportion of patient discharged from hospital to their **usual place of residence**

Improvements in LLR (2)

ELECTIVE CARE:

- **Elective activity growth** increased as a percentage of 19/20 baseline (rank 7/ 42)
- Improvement in October 2022 compared to 19/20 baseline of **diagnostic imagining** activity levels
- Improvement in October 2022 compared to 19/20 baseline of **endoscopies** (rank 10/ 42)
- Decrease in **104 week waits** for all LLR patients at all LLR providers meeting the local target in November 2022
- **Outpatient follow up** activity met the threshold and above 19/20 baseline.

Improvements in LLR (3)

MENTAL HEALTH:

- Increase in the number of people with **severe mental illness** receiving a full annual physical health check and follow up compared to this time last year.
- LLR continues to meet target of zero for adult acute mental health **out of area** placements.

LEARNING DISABILITIES & AUTISM:

- Percentage of people aged 14+ with a **learning disability** who are on the GP register receiving an annual health check is higher than this time last year.

Improvements in LLR (4)

GENERAL PRACTICE :

- **General Practice**: Number of to GP appointments per 10,000 weighted patients has increased compared to 19/20 levels (rank 4/ 42)
- Increase in **same day primary care** appointments
- Percentage of Atrial Fibrillation patients with a record of CHA2DS2 score treated with anticoagulation drug therapy increased and above threshold (rank 2/ 42)
- Percentage of **hypertension** patients treated as per the NICE guidance improvement from 50% in March 2021 to 62.9% in March 2022 (rank 7/ 42)
- Patients identified as having 20% or greater 10 year risk of **developing CVD** treated with statins above threshold and increased from last year (rank 10/ 42)
- Improvement in GP referrals to NHS **weight management services** (rank 11/ 42)
- Proportion of diabetes patients receiving all **8 diabetic care processes** improved to 45.7%
- **FTE doctors in general practice** per 10,000 weighted patients also increased (rank 3/ 42)

Improvements in LLR (5)

MEDICINE OPTIMISATION:

- **Community pharmacy consultant service** numbers increased from 8.6/100,000 in March 2021 to 101.3/100/000 in March 2022
- Improvement in the number of **broad-spectrum antibiotic** (antibacterials) items as a percentage of the total number of antibacterial items prescribed in primary care between August 22 compared to August 21

MATERNITY:

- Less **neonatal deaths** in December 2020 than December 2019.

CANCER:

- **Bowel cancer screening** rates increased in Leicester and Leicestershire from 2019 to 2021.

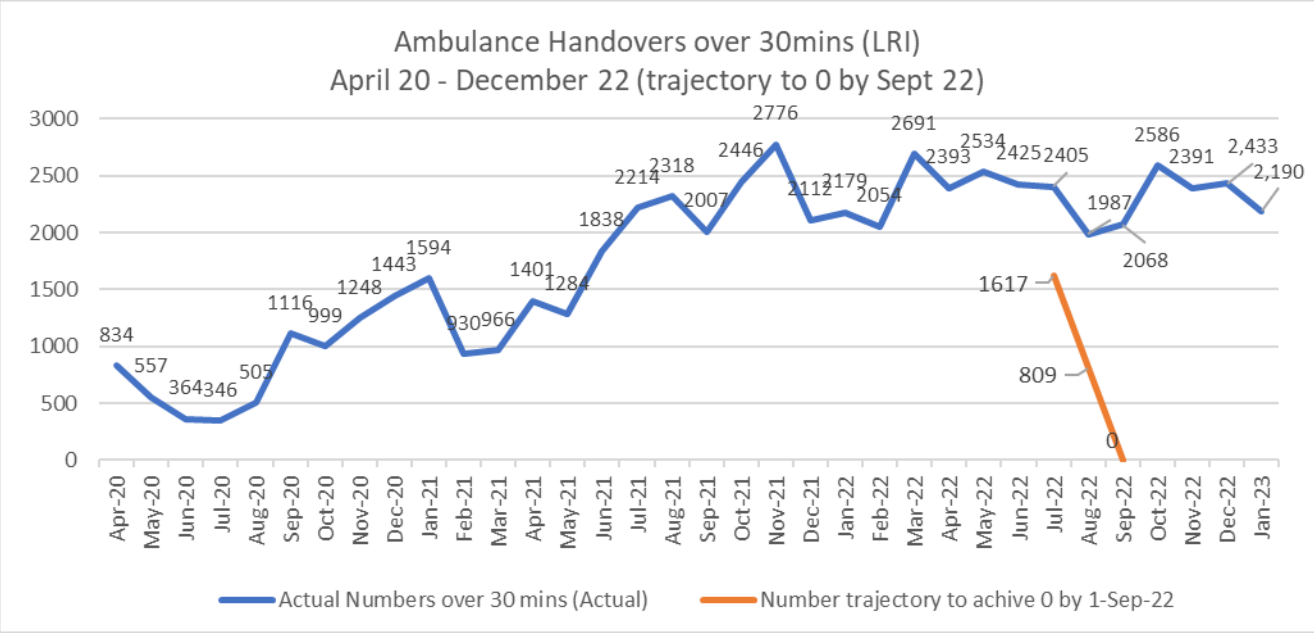
Improvements in LLR (6)

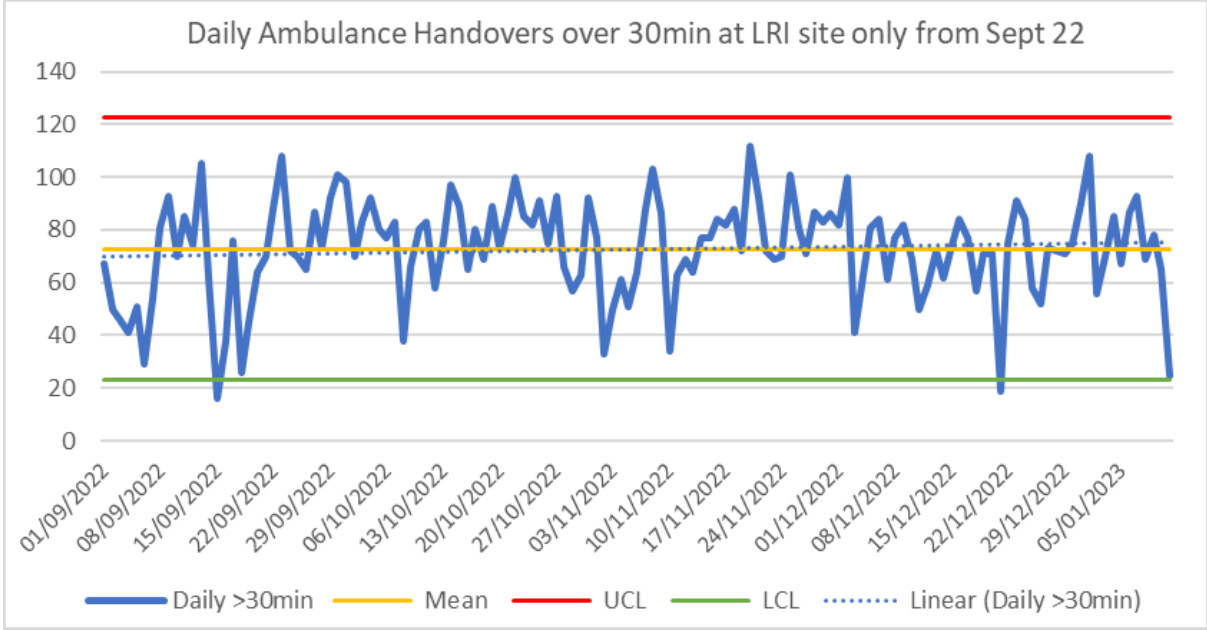
- Proportion of people referred to a **post covid service** who are assessed by a health care assessment within 6 weeks of referral increased from 11.3% in February 2022 to 67.6% in November 2022.
- Over **65 flu vaccination** rates improved in 2022 compared to 2021.
- Improvement in number of **personalised care interventions.**
- Improvements in proportion of staff who say they have experienced **harassment bullying or abuse from:**
  - Managers
  - Colleagues
  - Patients / service users (rank 1/ 42)
- Proportion of staff in senior leadership roles who are **women** has increased.

Oversight Framework- Urgent Care & emergency Care

	22/23 System Oversight Framework reference	Metric	Threshold	Nov-21	Nov-22	Direction of performance
URGENT AND EMERGENCY CARE	S0103a	Proportion of patients spending more than 12 hours in an emergency department	<2%	605	1110	⇩
	S122a	Mean 999 call answering times		No National data available		
	S123a	Adult general and acute type 1 bed occupancy (adjusted for void beds)	<92%	Dec 21 92.9%	Oct- 22 94.4%	⇩
	S124a	Percentage of beds occupied by patients who no longer meet the criteria to reside.		Apr 22- 13.6%	Nov 22 - 12%	⇧
		Ambulance waits		2021/22 Nov-21	2022/23 Nov-22	
	SO19a	Ambulance Handovers- delays over 30 minutes as a proportion of ambulance arrivals	N/A	834	889	⇩
	S020a	Cat 1 - Mean	<7mins	00:08:45	00:08:38	⇧
	S020b	Cat 2 - Mean	<18 mins	01:04:45	01:07:29	⇩
	S020c	Cat 3 - 90th centile (mean not available)	<2hrs	09:33:09	08:40:04	⇧
	S020d	Cat 4 - 90th centile (mean not available)	<3hrs	04:25:53	06:37:39	⇩

Ambulance Handovers over 30mins at LRI site





The graph above shows the monthly number of ambulance handovers waiting over 30mins at the LRI site only, against the trajectory of achieving 0 (zero) by 01-Sept-22

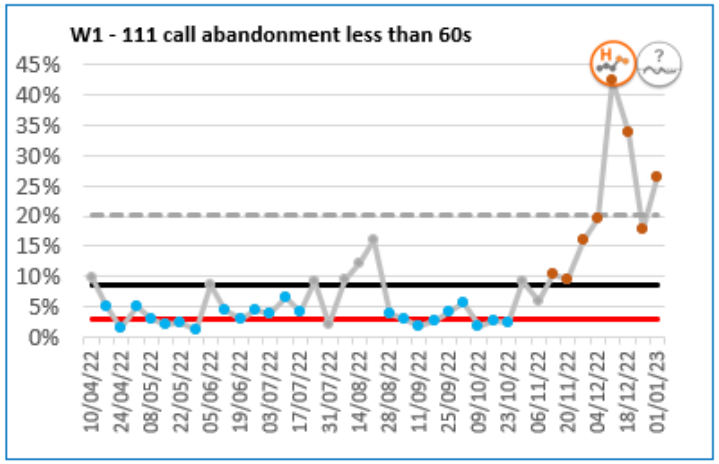
At the end of each reporting month, the number of >30min handovers is refreshed and therefore is likely to increase (by c.150 each month) compared with 'live' daily data.

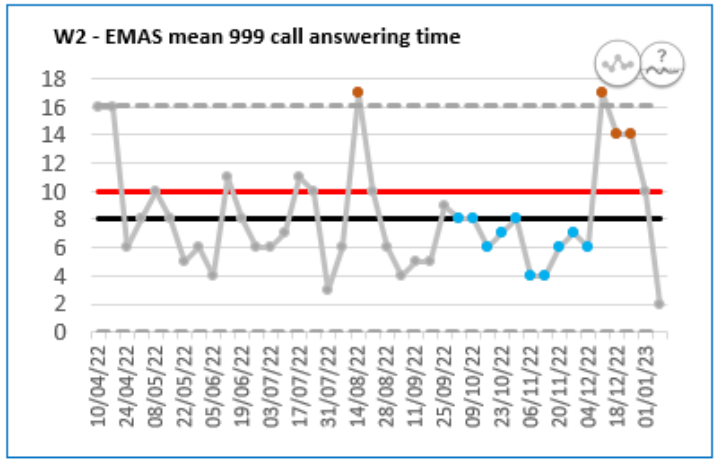
The SPC graph above shows a small increase in the daily number of ambulance handovers waiting over 30mins at the LRI site, from Sept 22.

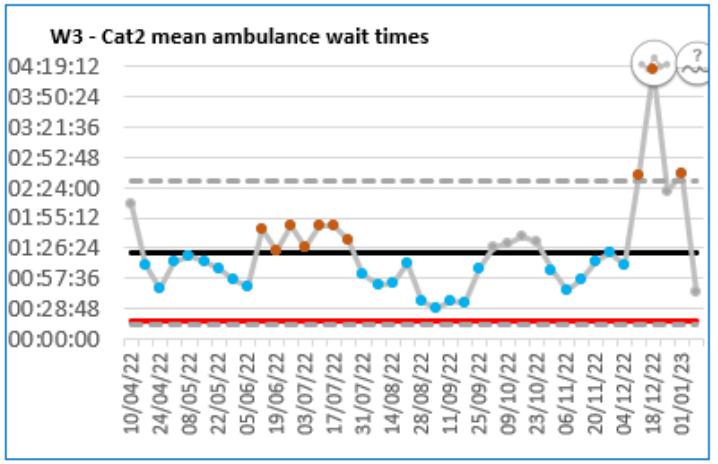
To note: Wed 21st Dec and 11th Jan were EMAS strike days, with 19 and 25 over 30min handovers respectively (a special cause on the above graph).

6 Winter Plan Urgent Care Metrics

NHSE/I require 6 Urgent Care metrics be reported locally and also form part of the monthly Winter Plan Assurance Framework. These 6 metrics are now being reported weekly, using the Making Data Count approach. National & local targets have been applied.







= special cause variation of particular **concern** and needing action

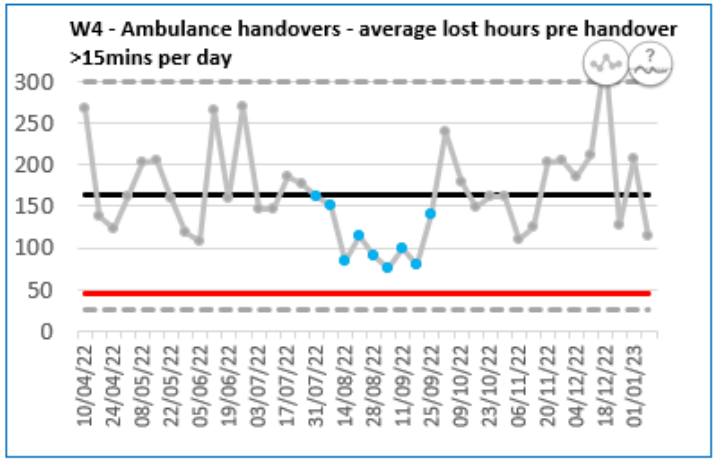
= special cause variation indicating **improvement**

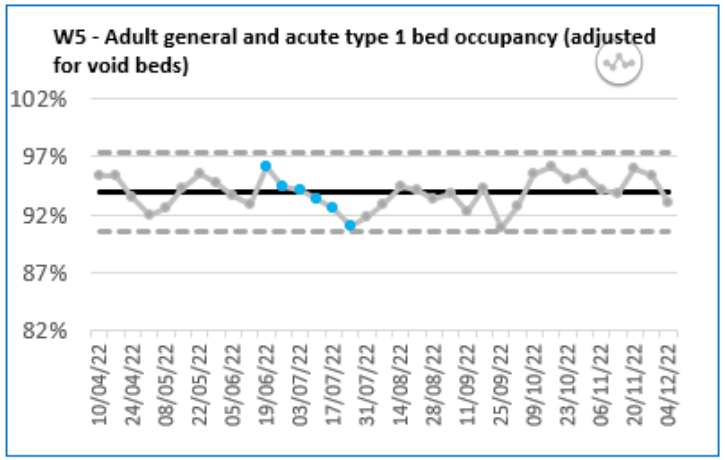
=no significant change (common cause variation)

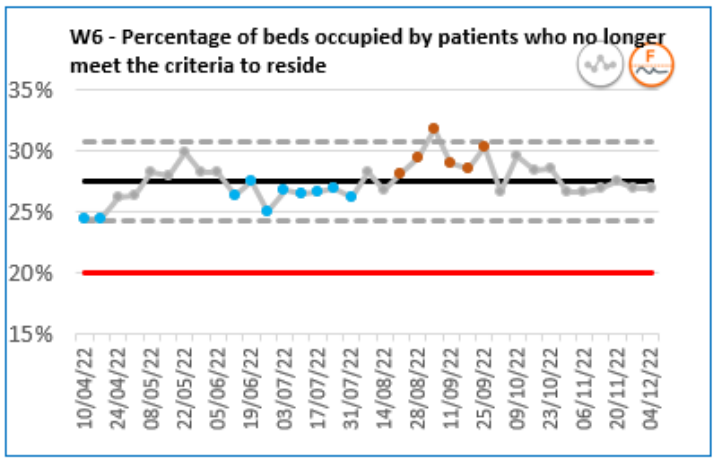
= target

= mean

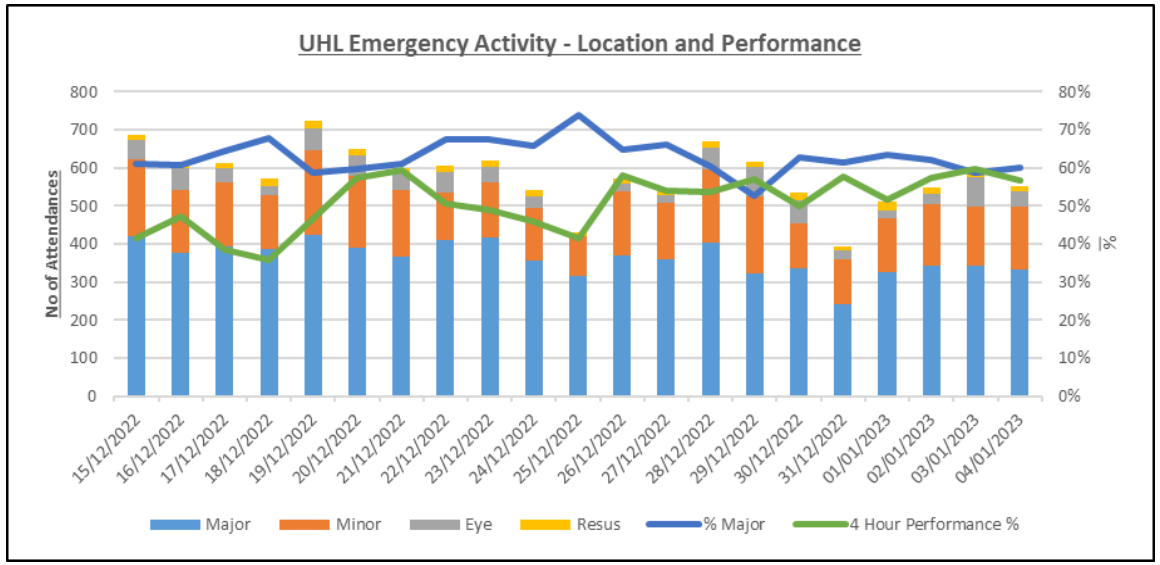
= upper and lower control limits







Emergency Department

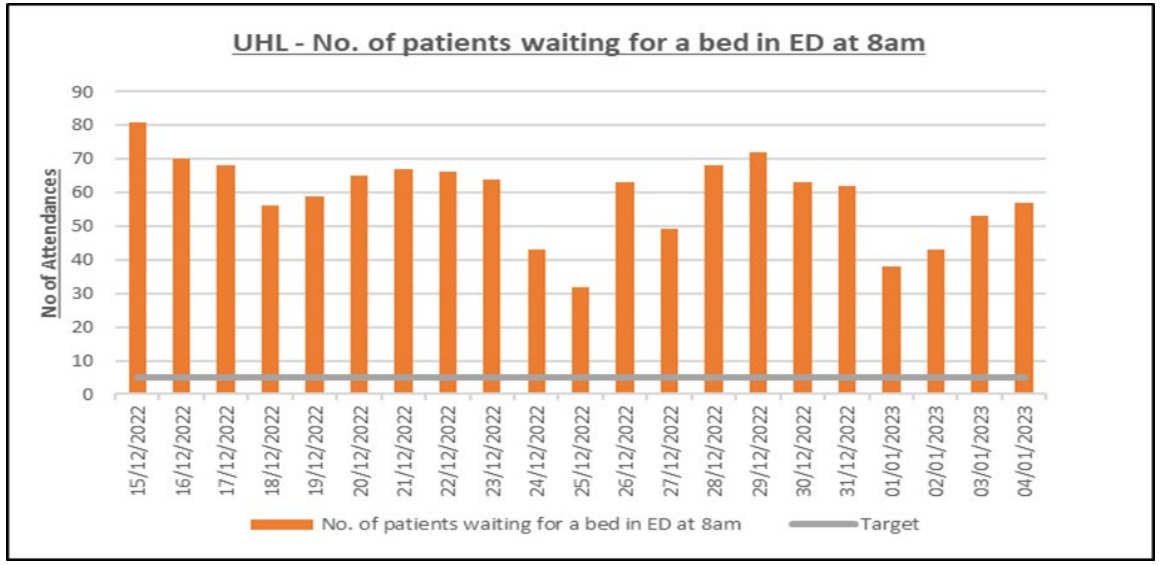


UHL Emergency Activity - Location and Performance

Graph to show the ED attendances by area, % that are Majors and overall 4hr wait performance, over the past 3 weeks, which includes MIaMI activity.

There has been a reduction in ED activity (🡻 2.0%) from November to December 22.

Overall children's has reduced (🡻 3.2%) and adults has reduced (🡻 1.4%) attending ED compared for the same period.



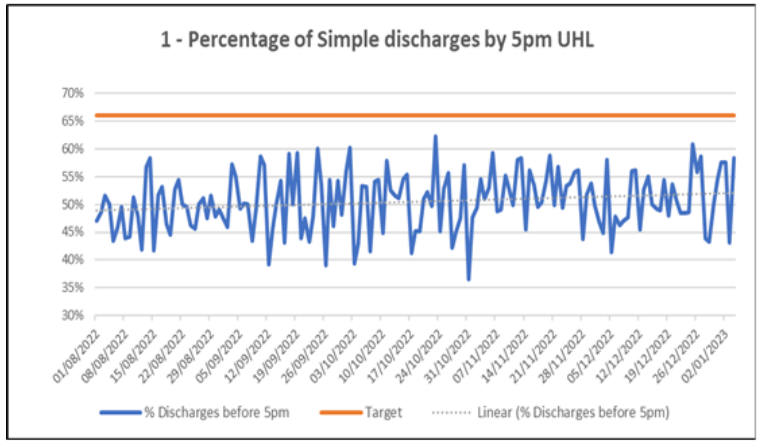
Numbers of patients awaiting beds in ED at 8am each morning at UHL

The number of patients waiting for a bed in ED at 8am has increased from November to December (🡹 9.0%)

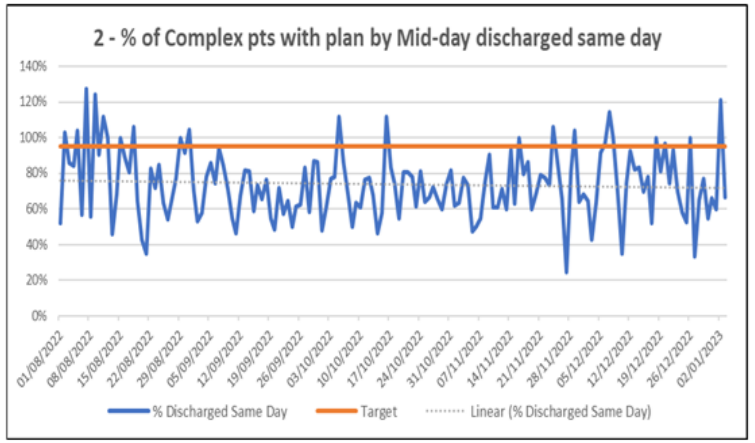
Discharges

WINTER PLAN KEY DELIVERABLE W18 100 day discharge challenge
(Implement an efficient and effective discharge process within providers to enable simple discharges by 5pm and 85% of complex discharges same day)

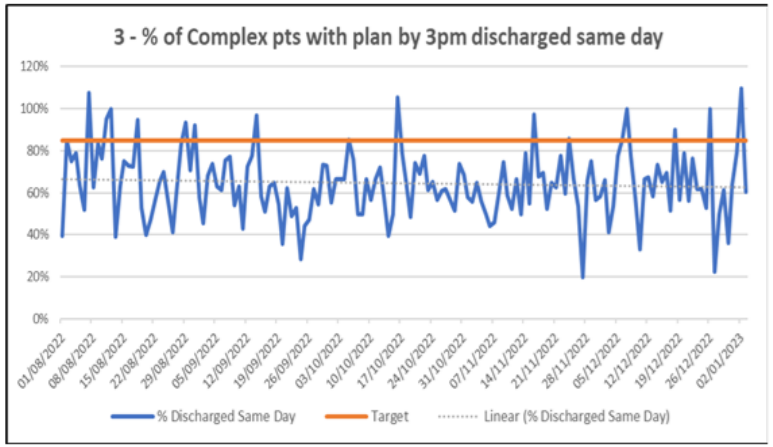
1 - Simple discharges by 5pm UHL



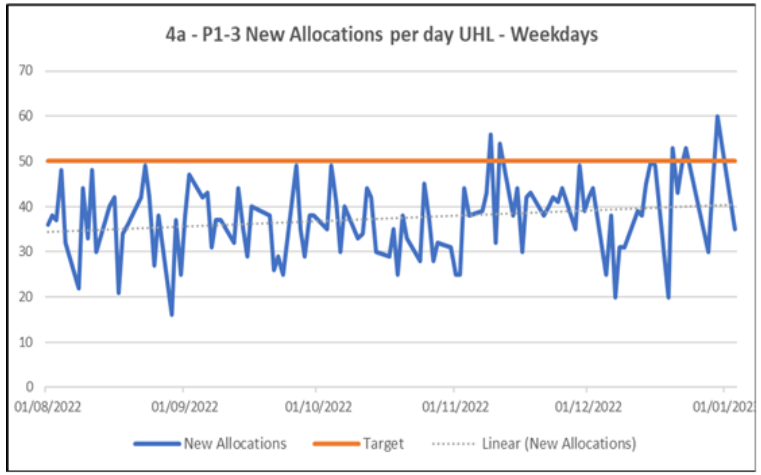
2 - Complex pts with plan by Mid-day discharged same day



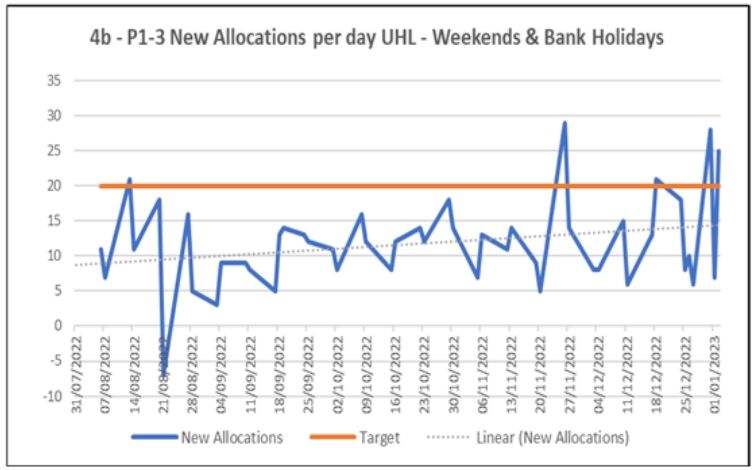
3 - Complex pts with plan by 3pm discharged same day



4a - P1-3 New Allocations per day - Weekday



4b - P1-3 New Allocations per day - Weekend & Bank Holidays



- **Chart 1** shows the percentage of Simple (PO) discharges each day that were discharged by 5pm. The target is 66% per day which we are currently not meeting.
- **Chart 2** shows the percentage of Complex (P1-P3) patients that had a plan to be discharged by Mid-day each day that were actually discharged on that day. The target is 95%. This is not routinely being met.
- **Chart 3** shows the percentage of Complex (P1-P3) patients that had a plan to be discharged by 3pm each day that were actually discharged on that day. The target is 85%. This is not routinely being met.
- **Chart 4a** shows the number of New Allocations (Planned discharges for today minus delays from the previous day) per weekday against a target of 50 per weekday.
- **Chart 4b** shows the number of New Allocations (Planned discharges for today minus delays from the previous day) per weekend/Bank Holiday against a target of 20 per day on weekends/Bank Holidays. Due to the reduced number of planned discharges at the weekend this could be a negative number if the number of delays from the previous day was higher.

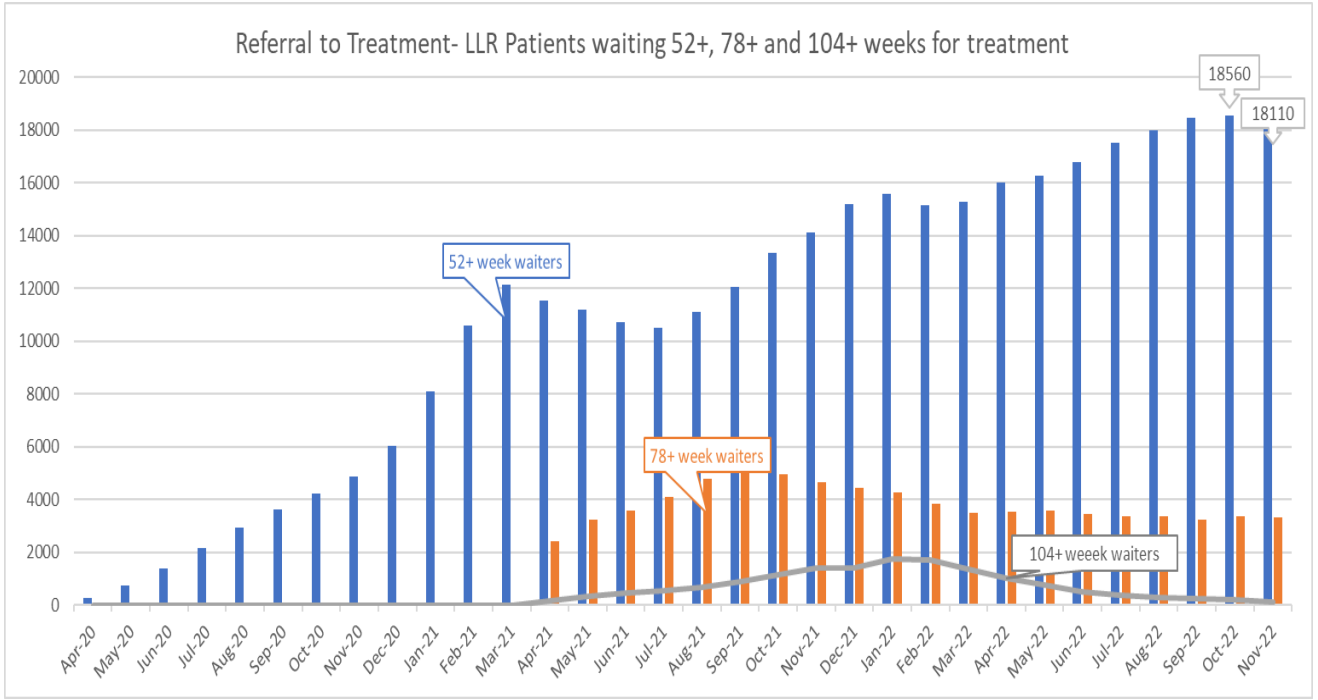
Oversight Framework- Elective Care

	22/23 System Oversight Framework reference	Metric	Threshold	Oct-21	Oct-22	Direction of performance
ELECTIVE CARE	S007a	RTT - Value weighted elective activity growth as a percentage of 2019 /20 baseline	104%	Sep- 21 89.9%	Sep- 22 105.1%	⇧
	S007b	RTT - Elective activity: Completed pathway elective activity growth	110%	77.7%	99.4%	⇧
	S009a	RTT - Patients Waiting over 52weeks	Zero	13,355	18,560	⇩
	S009b	RTT - Patients Waiting over 78weeks	Zero	4,931	3,358	⇧
	S009c	RTT - Patients Waiting over 104weeks	Zero	1,151	194	⇧
	S013a	Diagnostic activity levels - Imaging	19/20 baseline	Oct 19- 90.9% Oct 20- 84.4% Oct 21- 94.4%	98.6%	⇧
	S013b	Diagnostic activity levels – Physiological measurement	19/20 baseline	Oct 19- 95.9% Oct 20- 76.4% Oct 21- 69.9%	87.1%	⇧
	S013c	Diagnostic activity levels – Endoscopy	19/20 baseline	Oct 19- 95.6% Oct 20- 82.3% Oct 21- 104.8%	101.5%	⇩
	S013d	Diagnostic activity levels – Total	19/20 baseline	Oct 19- 91.5% Oct 20- 83% Oct 21- 92.3%	97.5%	⇧

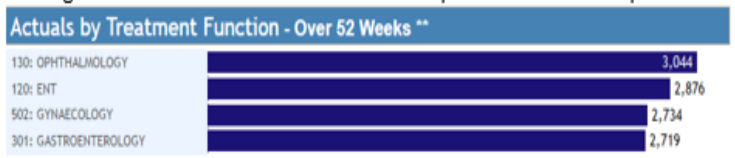
Elective Long Waits (LLR patients at all LLR providers)

The total LLR waiting list size at the end of November was 139,063 a **reduction of over 1200** LLR patients from Oct which stood at 140,632.

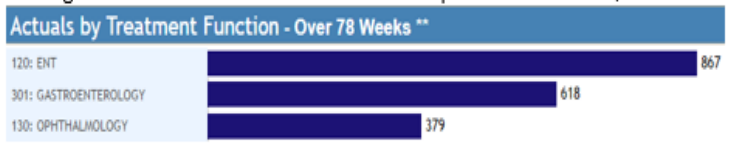
52+ week waiters at the end of Nov stood at 18,110, **a decrease** of 450 patients from Oct.
At the end of Nov, 78+ week waiters stood at 3316 and 104+ week waiters stood at 129.
Local target *for 104+week waiters was to achieve 140 by end of Nov - local target achieved . Target to achieve 101 by end of Dec*



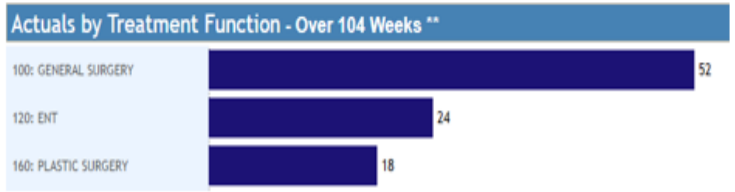
The highest number of 52+ wk. waiters for LLR patients remain in Ophthalmology, ENT, Gynaecology and Gastroenterology



The highest number of 78+ wk. waiters for LLR patients are in ENT, Gastroenterology and Ophthalmology



The highest number of 104+ wk. waits for LLR are in General Surgery, ENT, and Plastic Surgery



Elective Care remains significantly challenged however there continues to be good progress on the reduction of those patients waiting the longest for definitive treatment. **Actions in place at UHL:**

- Agreement with IS providers to transfer whole pathway (from first OPA to surgery). Increase in numbers sent to Nuffield and BMI Park
- Continued transfer of patients to Trentcliffs IS provider for complex General Surgery, Urology and Bariatric surgery
- Recruitment to Patients Access and Co-ordination team (Mutual Aid and IS team) following successful NHSE bid

Highlights & Delivery (12.01.23)

104+

- End of Jan 2023 forecast UHL 78 / System 94
- Route to zero by March 2023

78+

- Cohort to end of March continues to reduce – 9,306 (Pre-Christmas 9,980). 85% of the cohort is Non-admitted. Mainly ENT, Gastro and Gynae
- 8,003 Non admitted – 1,940 with a date before end of March. 125 dated April onwards to be b/f. Mainly Gynae.
- 1,303 admitted – 169 with a date before end of March. 2 TCIs in April.
- Forecast remains 2,765 to end of March 23

National asks before end of Jan:

- All 52+ weeks validation to be completed - As of 6th January, 83% have been validated in the last 12 weeks. This leaves 2,035 patients remaining to be validated. This will be achieved by 20th January 23.
- All non-admitted first OPA have an identifiable date before end of March 23 - **3,632 to book**
- All admitted have an identifiable TCI before end of March 23 – actions identified to reduce gap but not close. Will be conversion from non admitted.

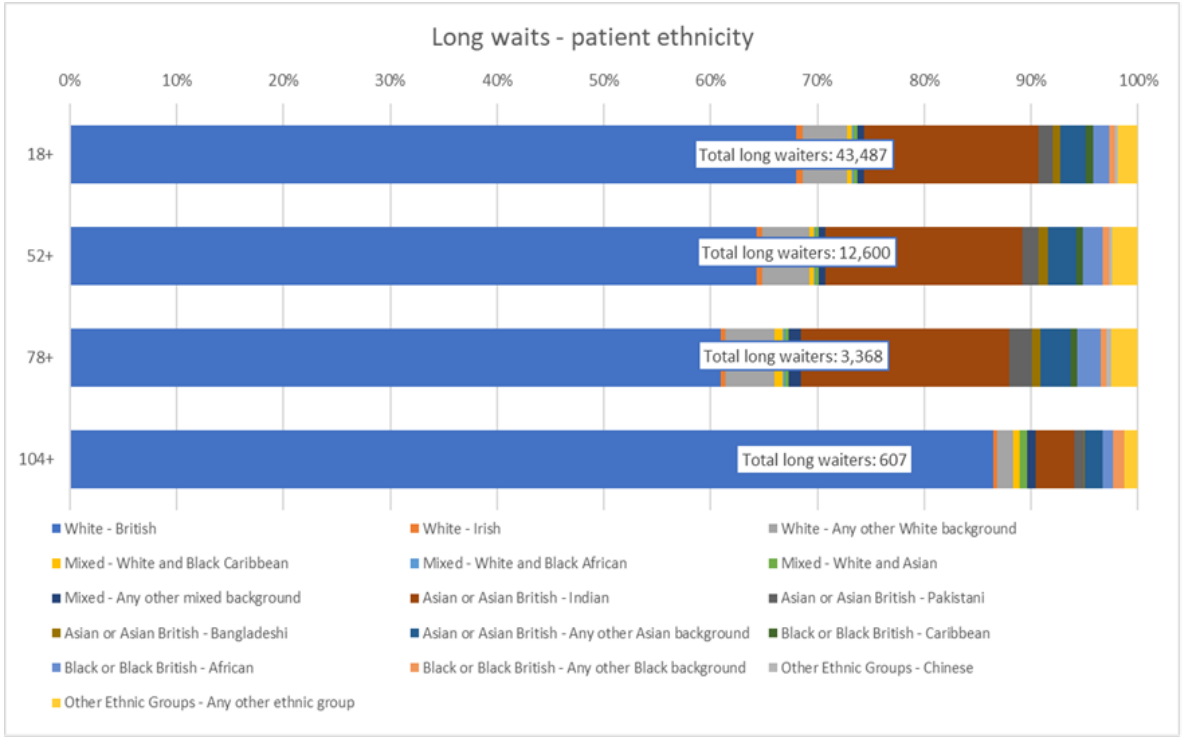
Cancer

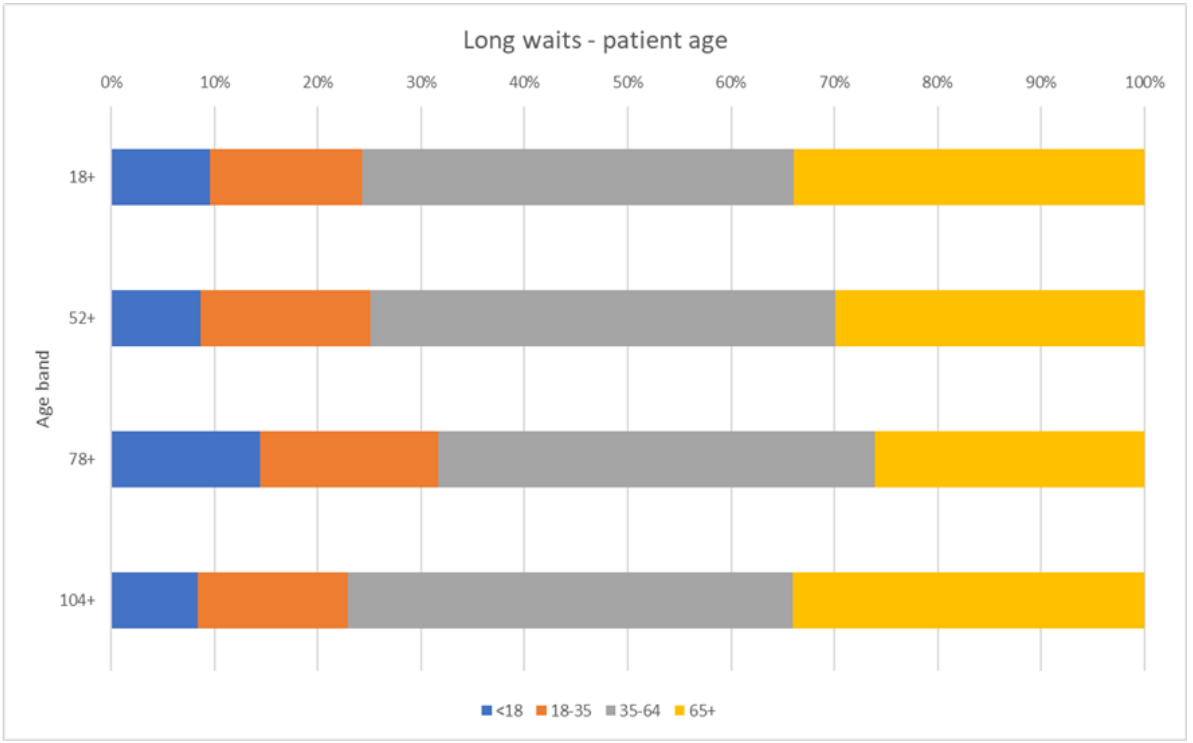
- Overall waiting list now under 4,000 patients at 3,982 (at November was 4,856)
- Backlog at 774 / 19 patients above revised trajectory
- IST weekly support starting 07/02

Diagnostics

- Draft trajectories shared with Region for waiting list size / 6+ week and 13 week on 11/01.
- 13+ week reduces from 14,161 at end of October to 9,641 by end of March 23 – 32% reduction. Needs to be at 50% reduction.
- Additional activity in place for NOUS and ECHO - small amount of conservatism in forecast as first week of use
- Focus on booking for Endoscopy – Insourcing option will not impact until April / May 23
- No immediate solutions currently identified for DEXA
- SoS exploratory request to expand additional diagnostic capacity 1st Feb – March 2024. LLR submission 12/01 Capital (£16.7m) and Revenue (£16m). Aligns to CDC / known capacity gaps – including workforce.

Elective Waiting List: ICB by Age & Ethnicity





DATA: up to 25.12.22

The largest cohort of patients waiting for treatment are aged 35 to 64 years (42.5%) followed by over 65 years (32.7%). This pattern is similar across all waits.

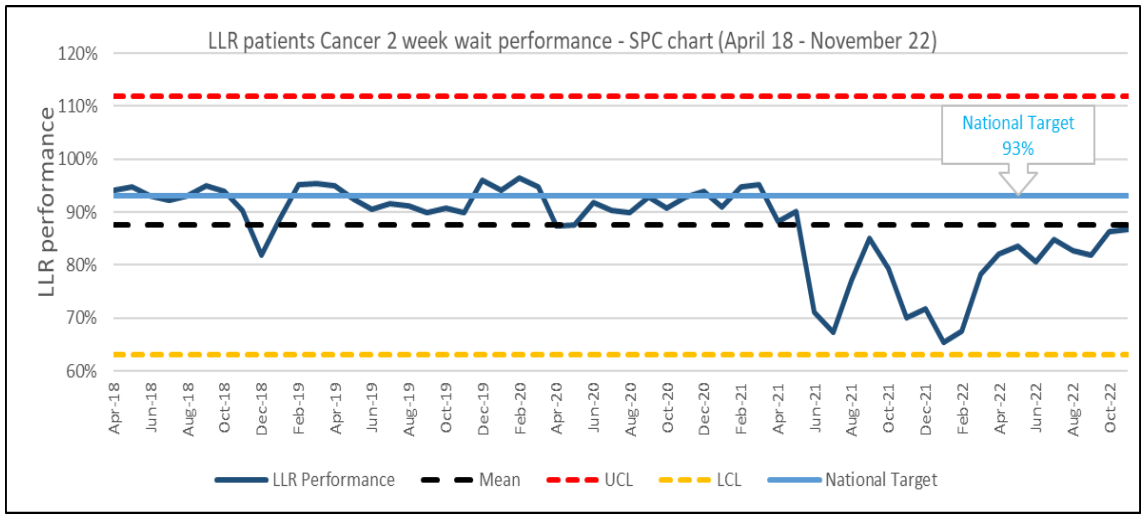
Patients of white ethnicity make up 71.8% of the total waiting list.

Oversight Framework- Cancer

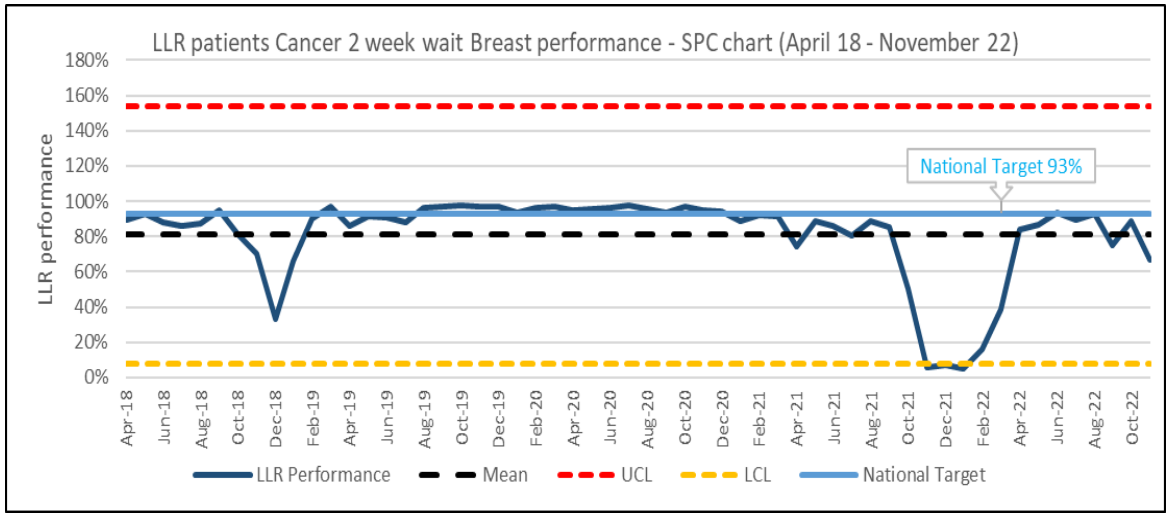
	22/23 System Oversight Framework reference	Metric	Threshold	Oct-21	Oct-22	Direction of performance
CANCER	S010a	Cancer 31 day First definitive treatment- Total patients treated for cancer compared with the same point in 2019/20	100%	Oct 20-87.1% Oct-21-78.7%	95.9%	⇧
	S011a	Cancer 62 day waits - Total patients waiting longer than 62 days to begin Cancer treatment (UHL)	N/A	w/e 05/12/21- 10.8% 12/12/21- 11.3% 19/12/21- 11.6% 26/12/21- 13.9%	w/e 4/12/22- 16.4%	⇩
	S012a	Proportion of patients (%) meeting faster diagnosis standard (All)	>75%	76.2%	74.0%	⇩

Cancer Waits

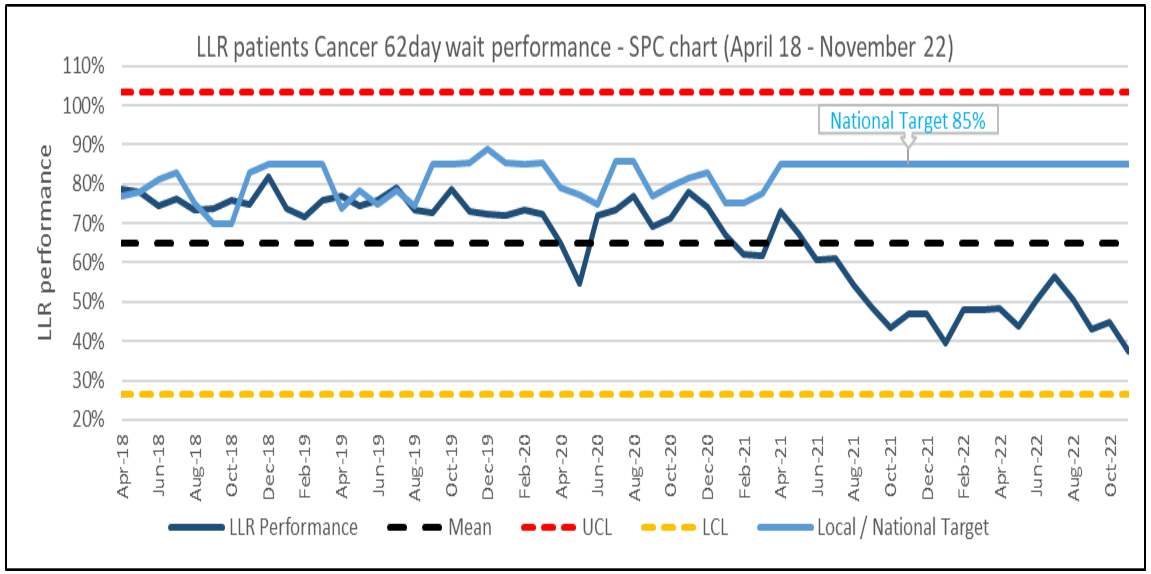
2 week wait Cancer Performance for LLR patients at all LLR providers



2 week wait Breast symptom Performance for LLR patients at all LLR providers



62 day wait Performance for LLR patients at all LLR providers



November's performance for the 2 week wait stands at 87% and shows a marginal improvement from October (86%). 2 week breast symptom (Nov 67%, Oct 89%) and the 62 day wait (Nov 38%, Oct 45%) have seen a deterioration from October.

Two week referral rate continue to be significantly above pre-pandemic levels and challenges remain in all tumour sites. Capacity and workforce pressures continue to be the biggest constraint. The 2WW demand and backlogs continue to directly impact on performance and whilst backlog clearance continues it adversely affects the 62-day performance. **Actions in place at UHL:**

- Haematology is due to pilot a 2ww triage service via PCL that has now been approved via the system Cancer Design Group which is anticipated to support a reduction in inappropriate 2ww referrals.
- Clinical review of PTL to support Urology and Colorectal. Regional support for Urology; including mutual aid continues, with the addition of Trent Cliffe (Scunthorpe) taking a number of nephrectomies
- NHSE investment to support Oncology/Radiotherapy/Haematology

Oversight Framework- Mental Health Services and Learning Disabilities & Autism

	22/23 System Oversight Framework reference	Metric	Threshold	Oct-21	Oct-22	Direction of Performance
MENTAL HEALTH SERVICES	S081a	IAPT – Access - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period.	TBC	Sep 2019- 67.7% Sep 2021- 76.7%	Sep 2022- 54.4%	⇩
	S084a	C&YP MH Access Children and young people (ages 0-17) mental health services access (number with 1+ contact) (12 mth rolling)	TBC			
	S085a	SMI Health Checks - People with severe mental illness receiving a full annual physical health check and follow up interventions	TBC	Sep 21- 2672 SMI register-10,437.0	Sep 22- 4932 SMI register-11,298	⇧
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external only) - rolling 3-month	0	Apr 21- 45 May 21- 65 Jun 21- 50 July 21- 50 Aug 21- 0 Sept 21- 0	Apr 22- 0 May 22- 5 Jun 22- 60 July 22- 60 Aug 22- 55 Sept 22- 0	⇔
	S110a	Access rates to community mental health services for adult and older adults with sever mental illness				
	S125a	Adult Acute LoS Over 60 Days % of total discharges			25.6%	
	S125b	Older Adult Acute LoS Over 90 Days % of total discharges		27.8%	26.7%	⇧

	22/23 System Oversight Framework reference	Metric	Threshold	2021-22 Q2	2022-23 Q2	Direction of performance
LEARNING DISABILITIES AND AUTISM	S029a	Adult Inpatient with a learning disability and/or autism per million head of population	30/million adult population by March 2024	43 per 1,000,000	34 per 1,000,000	⇧
	S029b	LD Children Inpatient - under 18 inpatients with a learning disability and/or autism who have a mental disorder and are in a specialis hospital bed(per million under 18 population)	12-15/million under 18 population by March 2024	April 22 - 4	Nov 22 - 10	⇩
	S030a	LD annual health check - Percentage of people aged 14+ with a learning disability on the GP register receiving an annual health check	75% by March 2024	June 22 9%	28.2%	⇧

Learning Disabilities & Autism (LDA)

Number of Annual Health Checks (AHCs) carried out for persons aged 14+ on GP Learning Disability Register

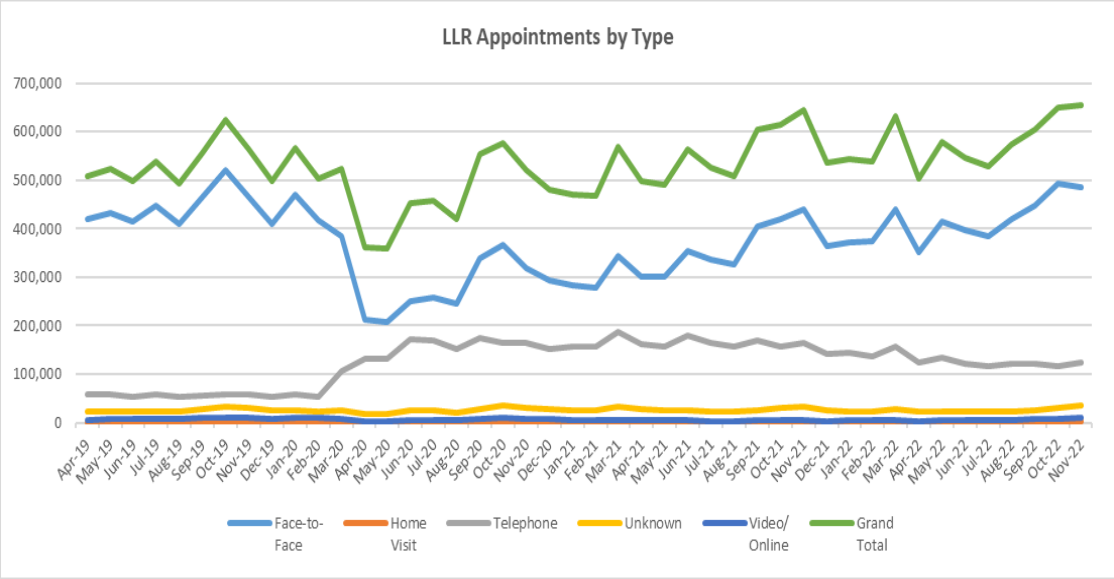
From national data sources LLR had 1939 completed AHC's from April 22 to the end of November 22. This is below the Q1-Q3 target of 2817. In previous years there has been an increase in HCs completed in Q3 and Q4.

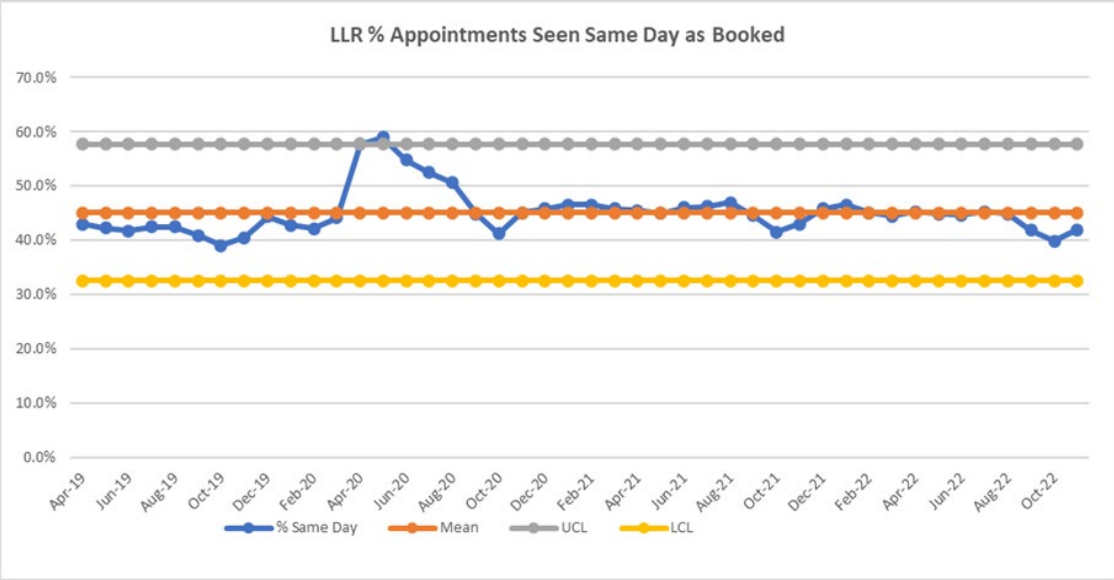
Sub-ICB	Monthly count of patients aged 14+, on the practice's LD register who have received a learning disability health check by the GP practice								22/23 HC's Year to date	Q1 - Q3 only 22/23 Plan
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		
East Leicestershire and Rutland	22	30	43	76	38	101	81	97	488	
Leicester City	33	38	82	96	234	138	133	138	892	
West Leicestershire	22	37	91	73	72	91	53	120	559	
LLR IBC	**77**	**105**	**216**	**245**	**344**	**330**	**267**	**355**	**1939**	**2817**

Oversight Framework-Primary & Community Services

	22/23 System Oversight Framework reference	Metric	Threshold		Oct-22	Direction of performance
PRIMARY CARE AND COMMUNITY SERVICES	S001a	Number of general practice appointments per 10,000 weighted patients	N/A Includes face to face, telephone, home visit, video/online	April 22 4742.96 per 10,000	6124.11 per 10,000	⇧
	S105a	Discharges- Proportion of patients discharged from hospital to their usual place of residence	N/A	Provider UHL- 31 Oct 19-92.5% 31 Oct 20-93.4% 31 Oct 21-91.9%	Provider UHL- 31 Oct 22- 92.5%	⇧
				Sub-ICB ELR- Oct 19-91.3%, Oct 20- 92.2%, Oct 21- 89.3% LC- Oct 19- 93.2%, Oct 20- 94.7%, Oct 21- 93.7% WL- Oct 19- 92.2%, Oct 20- 92.8%, Oct 21- 92.1%	Sub-ICB Oct 22 ELR - 91.4% LC -93.7% WL - 92.8%	
	S106a	Virtual Ward- available virtual ward capacity per 100,000 head of population	National ambition 40-50 virtual ward 'bed' per 100,000 of adult population by Dec 2023	30 Apr 22 10.3 per 100,000	31 Oct 22 7.4 per 100,000	⇩
	S107a	2-hour urgent response activity- Proportion of Urgent Community Response referrals reached within two hours	70.0%	30 Apr 22 73.9%	30 Sep 22 85.7%	⇧
	S108a	Community Pharmacist Consultation Service (CPCS)- number of completed Referrals to CPCS from: **a. General Practice and**	N/A	31 Mar 21 8.6 per 100,000	31 Mar 22 101.3 per 100,000	⇧
	S108b	**b. NHS 111 per 100,000 population**	N/A	31 Mar 20 36.5 per 100,000 31 Mar 21 48.9 per 100,000	31 Mar 22 63.1 per 100,000	⇧
	S109a	Dental activity - Units of dental activity delivered as a proportion of all Units of dental Activity contracted Primary and community services including new community services response times	100% Benchmark:Pre-pandemic delivery of contracted UDAs	30 Sep 21 56.1%	30 Sep 22 73.9%	⇧

General Practice Appointments





National weekly data was discontinued from 20-Oct-2022 and data is now only available by month. December data available from 26th Jan.

Data source: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

All Appointments	Total
Nov-19	562,391
Nov-20	521,001
Nov-21	643,907
Nov-22	654,370

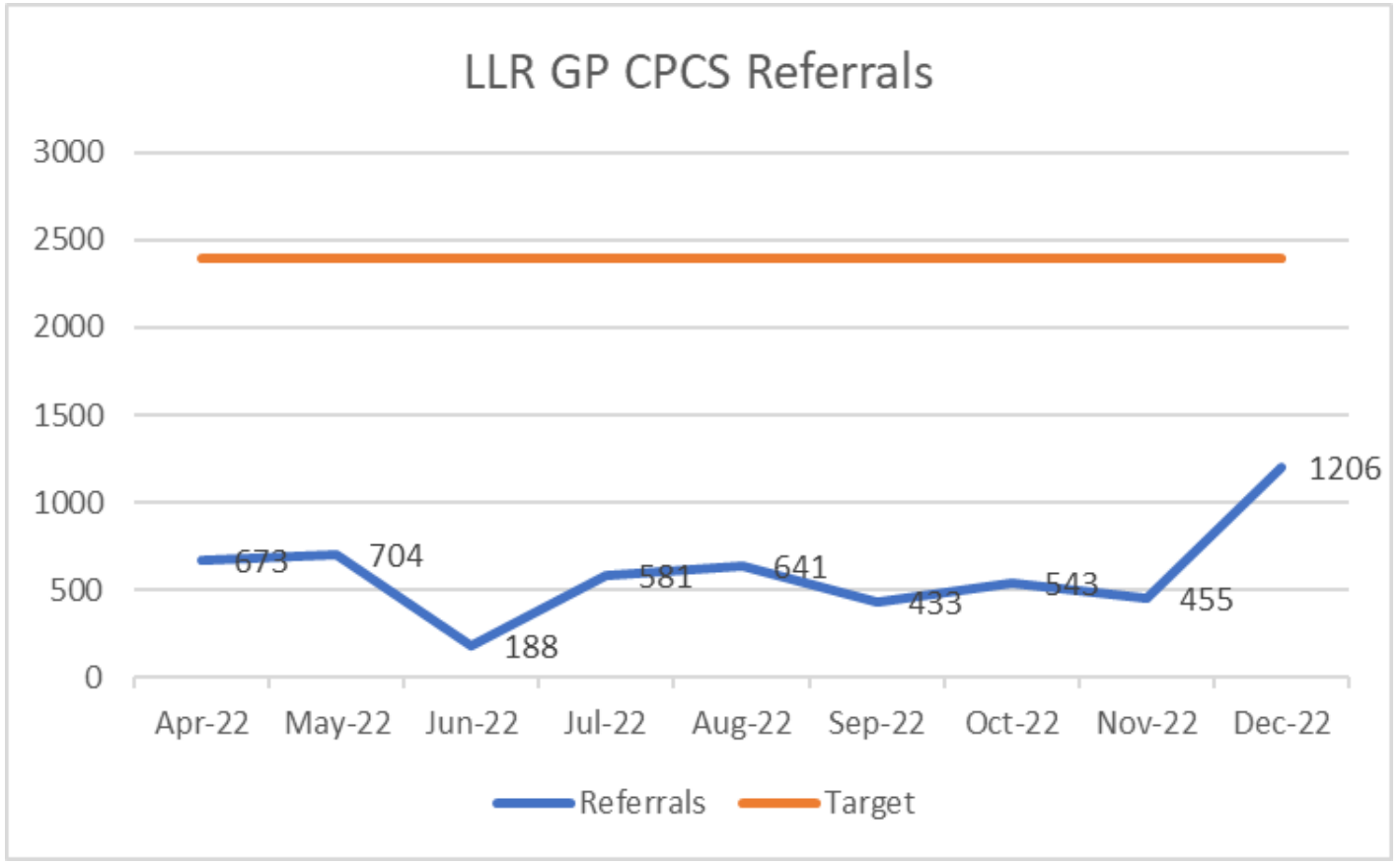
Appointment Levels
Target – increase from 19/20
Performance: **Target met**
The graph left shows the monthly number & type of general practice appointments April 2019 and November 2022. Total appointment types shows an increase (🡅 0.6%) from October to November. This follows a 7.8% increase compared to the previous month (Sep - 603,319, Oct-650,288). The number of face-to face appointments has decreased (🡇 1.8%) compared to the previous month (Sep- 446,138, Oct- 492,995, November 484,076).

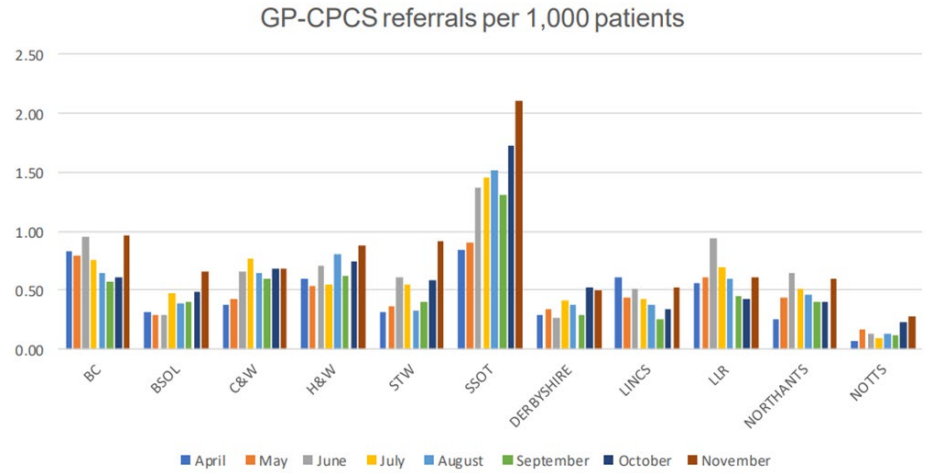
Same day appointments
Target – increase month on month
Performance: **Increase in Nov 22**
The graph left shows the % of appointments that took place on the same day they were booked. There has been little variation over the last two years (since Sept 2020), although there has been a slight dip in Sep/Oct in each of the last 3 years, with a figure of 41.8% for Sept 22 and 39.9% in Oct 22. The % of appointments seen on the same day as booked has increased (🡅 2.0%) from last month (41.9% in Nov 22).

Data source: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

Community Pharmacist Consultation Service (GP CPCS)

The first graph below the overall number of referrals made into the CPCS from Nov 21 to December 22. The graph on the right shows the level of referrals by region in the East Midlands. We are making links with SSOT as their referral rates are increasing month on month.





January 2023 Update

- ICB now in receipt of funding from NHSE for PharmOutcomes ITK referral solution.
- Demonstrations of the system to be scheduled for clinical colleagues.
- Rollout expected within the next month.
- Exploring referral pathway from UCCs / UTCs with DHU. Looking to include these sites in the rollout of PharmOutcomes.
- Working with DHU / NHS111 colleagues to increase referrals into CPCS by NHS111.

Oversight Framework- Maternity and Children's Health

	22/23 System Oversight Framework reference	Metric	Threshold	31-Dec-19	31-Dec-20	Direction of performance
MATERNITY AND CHILDRENS	S022a	Number of stillbirths per 1,000 total births	N/A	2.67 per 1,000	4.1 per 1,000	⇩
	S104a	Number of neonatal deaths per 1,000 live births	N/A	1.99 per 1,000	1.52 per 1,000	⇧

Oversight Framework- Outpatient Transformation

	22/23 System Oversight Framework reference	Metric	Threshold	31-Oct-21	31-Oct-22	Direction of performance
OUTPATIENT TRANSFORMATION	S101a	Outpatient follow up activity- relative number of follow-up outpatient attendances in 2022/23 compared to baseline 2019/20 expressed as a percentage	= > 75% by 1 Apr 2023 (min 25% reduction)	102.60%	101.40%	⇩

Oversight Framework-Personalised Care

	22/23 System Oversight Framework reference	Metric	Threshold			Direction of performance
PERSONALISED CARE	S031a	Number of personalised care interventions	N/A	Q2 21-22 26.85 per 1,000 Q3 21-22-32.21 per 1,000 Q4 21-22-39.49 per 1,000 Q1 22-23- 42.03 per 1,000	Q2 22/23 54.85 per 1,000	⇧
	S032a	Personal health Budgets	N/A	Q2 21-22-1.78 per 1,000 Q3 21-22-2.39 per 1,000 Q4 21-22- 2.72 per 1,000	Q1 22/23 1.17 per 1,000	⇩

Oversight Framework- Safe, High Quality Care

	22/23 System Oversight Framework reference	Metric	Threshold		Dec-22	Direction of performance
SAFE, HIGH QUALITY CARE	S034a	Summary Hospital-level Mortality Indicator- Deaths associated with hospitalisation (UHL)	N/A due to SHMI being a ratio	June 22 2- as expected	July 22 2- as expected	⇔
	S035a	Overall CQC rating (provision of high-quality care)	N/A	UHL (Nov 22) REQUIRES IMPROVEMENT		
				LPT (Nov 22) REQUIRES IMPROVEMENT		
	S037a	Patient experience of GP services- percentage of patients describing their overall experience of making a GP appointment as 'Good'	N/A	Dec 20- 61.8% Dec 21-67.9%	Dec 22- 52.8%	⇩
	S038a	Consistency of reporting patient safety incidents (UHL)	100%	Sep 2019-100% Sep 2020- 100% Sep 2021- 100%	Sep 22- 66.7%	⇩
	S039a	National Patient Safety Alerts not declared complete by deadline - number of National Patient Safety incidents that are not reported as completed (UHL)	No Outstanding alerts	No National data		
	S040a	MRSA - Infection rate (UHL)	Operational Standard as specified in the NHS Standard Contract is 0	Apr-22 1	Oct-22 3	⇩
	S041a	CDIFF - Clostridium difficile infection rate 12 month rolling	TBC	Apr-22 114.9%	Oct-22 149.5%	⇩
	S042a	E. coli bloodstream infections 12 month rolling	TBC	Apr-22 108.5%	Oct-22 110.1%	⇩
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	<87.1%	Aug 21 71.4%	Aug 22 84.2%	⇩
	S044b	Broad spectrum antibiotics in primary care	<10%	Aug 21 11.1%	Aug 22 10.1%	⇧
	S121a	NHS Staff Survey compassionate culture people promise element sub-score (replacing the safety culture theme score)	As per staff survey benchmarking group results		2021 7/10	
	S121b	NHS Staff Survey raising concerns people promise element sub-score (replacing the safety culture theme score)			2021 6.5/10	

Oversight Framework- Prevention and Long Term Conditions

	22/23 System Oversight Framework reference	Metric	Threshold	2021-22 Q2	2022-23 Q2	Direction of performance
PREVENTION AND LONG TERM CONDITIONS	S051	The number of people who have achieved Milestone 1 of the NHS Diabetes Prevention Programme, as a proportion of the number of people profiled to achieve Milestone 1	N/A	77.9%	66.2%	⇩
	S053a	% of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	90%	March 20- 90.6% March 21- 91.3%	March 22 92.1%	⇧
	S053b	% of hypertension patients who are treated to target as per NICE guidance	80%	March 20-70.3% March 21-50%	March 22 62.9%	⇧
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	45% (under review)	March 21 56.2%	March 22 58.8%	⇧
	S054a	% of patients receiving a thrombectomy following a stroke	10%	No national data available		
	S055a	Number of GP referrals to NHS digital weight management services- Number per 100k population	N/A	20.1 per 100,000	88.3 per 100,000	⇧
	S115a	Proportion of diabetes patients that have received all eight diabetes care processes		2020-21 Q4 31.6%	2021-22 Q4 45.7%	⇧
	S116a	Proportion of: a) adult acute inpatient offering Tobacco Dependence services or	100% coverage for both settings by the end of 2023/24.	Jun 22- 0% July 22- 0%	Aug 22- 0%	
	S116b	b) maternity settings offering Tobacco Dependence services		Jun 22- 0% July 22- 0%	Aug 22- 0%	
	S117a	Proportion of people referred to a post COVID service who are assessed by a registered health care assessment within 6 weeks of referral	N/A	Feb 22 -11.3% Mar 22- 24.8% Apr 22- 36.1%	Nov 22 67.6%	⇧

Oversight Framework-Screening, Vaccination and Immunisation

	22/23 System Oversight Framework reference	Metric	Threshold	2021-22 Q1	2022-23 Q1	Direction of performance
SCREENING, VACCINATION AND IMMUNINISATION	S046a	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)	>95%	91.1%	88.7%	⇩
	S047a	Proportion of people aged 65 and over who received a flu vaccination	85% (2021-22) 75% (2020-21)	Oct 2021 63.6%	Oct 2022 67.3%	⇧
	S048a	Bowel screening coverage, aged 60–74, screened in last 30 mths	Efficiency = 55%; Optimal = 60%	**Dec 2019** Leicester- 50.1% Leicestershire -66.8% **Dec 2020** Leicester- 52.9% Leicestershire-67.7%	**Dec 2021** Leicester -57.8% Leicestershire-73.8%	⇧
	S049a	Breast screening coverage, females aged 53–70, screened in last 36 months	Efficiency = 70%; Optimal = 80%	**Mar 2019** Leicester- 66.4% Leicestershire- 78% **Mar 2020** Leicester- 68% Leicestershire- 77.7%	**Mar 2021** Leicester -44.3% Leicestershire- 65%	⇩
	S050a	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 year coverage)	Efficiency = 75%; Optimal = 80%	2020-21 Q4 71.2%	2021-22 Q4 71%	⇩

Oversight Framework- Leadership and Capability

	22/23 System Oversight Framework reference	Metric	Threshold			Direction of performance
LEADERSHIP AND CAPABILITY	S059a	**CQC well-led** rating Quality of leadership - Based on CQC leadership rating for trusts and GP practices, and NHS England and NHS Improvement assessment for CCGs and ICSs. (UHL)		UHL (Nov 22) REQUIRES IMPROVEMENT		
				LPT (Nov 22) REQUIRES IMPROVEMENT		
	S060a	Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	As per staff survey benchmarking group results		2021 6.81/10	

Oversight Framework-Finance

	22/23 System Oversight Framework reference	Metric	Threshold			Direction of performance
FINANCE	S027a	Achievement of Mental Health Investment Standard	PASS			
	S118a	Financial Stability-variance from break-even	PLACEHOLDER			
	S119a	Financial efficiency-variance from efficiency plan	PLACEHOLDER			
	S120a	Agency Spend vs agency ceiling	100%			
	S120b	Agency spend price cap compliance	100%			

Oversight Framework-People

	22/23 System Oversight Framework reference	Metric	Threshold	Dec-20	Dec-21	Direction of performance
PEOPLE	S063a	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	11.7%	10.7%	⇧
	S063b	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues		19.1%	17.2%	⇧
	S063c	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public		23.4%	22.8%	⇧
	S067a	NHS Staff Leaver Rate-% of staff who have left the NHS during a 12-month period		Sep-19- 7.27% Sep-20 - 6.2% Sep-21- 6.71%	Sep-22 8.41%	⇩
	S068a	Sickness absence rate (working days lost to sickness)		Jul-19- 3.75% Jul -20 -3.45% Jul-21 - 4.16%	Jul-22 5.66%	⇩
	S069a	NHS Staff Survey - Staff engagement theme score	As per staff survey benchmarking group results	5.66/10	5.63/10	⇩
	S071a	Proportion of staff in senior leadership roles who are a) from a BME background,	**22/23-12%** 23/24-16% 24/25-20%	UHL 2019-6.54% 2020-8.59%	UHL 2021-6.92%	⇩
		b) women	**22/23-62%** 23/24-64% 24/25-66%	UHL Sep 2019-67.4% Sep 2020-68.3% Sep 2021-65.3%	UHL Sep 2022-66.5%	⇧
		c) disabled staff (proportion of staff who have declared a disability)	**22/23-3.2%** 23/24-3.6% 24/25- 4%	UHL 2019 -1.9% 2020 -2.3% 2021 -2.3%	UHL 2022 -2.1%	⇩
	S072a	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking group results	2020 56.6%	2021 56.3%	⇩
	S074a	FTE doctors in General Practice per 10,000 weighted patients	N/A	Apr 22- 6.46 per 10,000 May 22-6.41 per 10,000 Jun 22- 6.42 per 10,000 Jul 22- 6.37 per 10,000 Aug 22- 6.85 per 10,000	Sep 22 6.9 per 10,000	⇧
	S075a	Direct Patient Care staff in GP practices and PCNs per 10,000 weighted patient population	N/A		2022-23 Q1 4.91 per 10,000	

2022/23 NHS System Oversight Framework

NHSE/I provided an update on performance data for a number of key metrics from the 22/23 System Oversight Framework (SOF).

The following table provides details of those 22/23 metrics where LLR ICS are in the **highest** quartile (top 25%), and their rank against all reporting ICS's, according to the nationally produced dataset (20/12/22 release)

Jan-23		
NHS Oversight Framework Metric	**Period**	**Rank**
S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	1/42
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	2021-22	2/42
S074a: FTE doctors in General Practice per 10,000 weighted patients	2022 09	3/42
S108a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	2022 03	3/42
S001a: Number of general practice appointments per 10,000 weighted patients	2022 10	4/42
S007a: Total elective activity undertaken compared with 2019/20 baseline	2022 09	7/42
S012a: Proportion of patients meeting the faster cancer diagnosis standard	2022 10	7/42
S053b: % of hypertension patients who are treated to target as per NICE guidance	2021-22	7/42
S067a: Leaver rate	2022 09	8/41
S051a: Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	22-23 Q2	9/42
S013c: Diagnostic activity levels: Endoscopy	2022 10	10/41
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	2022 10	10/42
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	2022 03	10/42
S055a: Number GP referrals to NHS Digital weight management services per 100k population	22-23 Q2	11/42
S068a: Sickness absence rate	2022 07	11/42

The following table provides details of those 22/23 metrics where LLR ICS are in the **lowest** performing quartile (bottom 25%), and their rank against all reporting ICS's, according to the nationally produced dataset.

It should be noted that metrics vary in their frequency and timeliness of publication. (20/12/22 release)

Jan-23		
NHS Oversight Framework Metric	**Period**	**Rank**
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	2022 10	40/41
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	2022 10	40/41
S013a: Diagnostic activity levels: Imaging	2022 10	40/41
S013b: Diagnostic activity levels: Physiological measurement	2022 10	40/41
S013d: Diagnostic activity levels: Total	2022 10	40/41
S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 04/12/2022	40/42
S022a: Stillbirths per 1,000 total births	2020	39/42
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	2022 10	38/41
S041a: Clostridium difficile infection rate	2022 10	37/42
S037a: Percentage of patients describing their overall experience of making a GP appointment as good	2022	36/42
S042a: E. coli bloodstream infection rate	2022 10	35/42
S081a: Access rate for IAPT services	2022 09	35/42
S010a: Total patients treated for cancer compared with the same point in 2019/20	2022 10	34/42
S071a: Proportion of staff in senior leadership roles who are from a BME background	2021	34/42
S031a: Rate of personalised care interventions	22-23 Q2	33/42
S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	32/42
S123a: Adult general and acute type 1 bed occupancy (adjusted for void beds)	2022 10	32/42

N

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**9 February 2023**	**Paper:**	**N**
Report title:	**Summary Report from the ICB Quality and Safety Committee**		
Presented by:	Pauline Tagg, Chair of ICB Quality and Safety Committee		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB		
Sponsor:	Dr Caroline Trevithick, Chief Nursing Officer, LLR ICB Dr Nilesh Sanganee, Chief Medical Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Quality and Safety Committee meeting held on 5 January 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.
2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		Yes, assurance at pathway and provider level supporting improvements and input against the current risks of LLR BAF 01 and LLR BAF 02. This Committee will review risks associated with quality at design group / collaborative level on a quarterly basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		No.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		Yes. Quality and safety risks considered in the System Quality Report and the Primary Care highlight.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Verbal report Chairman of PPIAG.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		

Assurance Report from the ICB Quality and Safety Committee

1.0 Introduction

1.1 This report provides a summary of the key areas of discussion and outcomes from the ICB Quality and Safety Committee (QSC) held on 5 January 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

2.0 Terms of reference / Workplan

2.1 A revised version of the QSC Terms of Reference (TOR) was presented for review. The Chair noted that the ICB would be conducting a development session in January 2023 where it will be reviewing the current governance structure.

2.2 It was agreed to bring back the QSC TOR in March 2023 for approval following the ICB development session in January 2023.

2.3 It was noted that the QSC members felt strongly that moving to bi-monthly meetings would allow for improved assurance around patient experience by utilising the month when there is no formal meeting to undertake deep dives/targeted work and patient stories.

3.0 ICB Chief Nursing Officer/ Chief Medical Officer Quality Assurance Report

3.1 QSC members were informed that the LLR system had put in place adequate plans in response to industrial action and successfully utilised the Health Economy Tactical Coordination Group (HETCG) to oversee and direct its response to industrial action. It was noted lessons learned are being incorporated into the plans for future industrial action.

3.2 The design group for Children and Young People (CYP) have identified a number of system level quality and service risks. The System Executive have reviewed the concerns raised and are formulating a response to address the risks. It was noted this will be added to the QSC system risk register. The QSC members agreed that a deep dive into the concerns raised will be undertaken on the 2 February 2023.

3.4 It was noted Oakham Medical Practice had a follow up CQC inspection on the 28 November 2022 following its inadequate rating in April 2022 and a further Rapid Quality Review Meeting (RQRM) is scheduled in January 2023 to discuss the report, progress made, and any further support needed.

3.5 QSC members were updated that the ICB served notice to terminate the Spectrum Health contract on the 2 September 2022. Spectrum Health appealed the decision. The ICB has set aside the termination notice whilst the appeal process runs its course in line with the contractual guidance governing contracts. Mitigations are in place and the ICB continue to support and work with the practise partners.

3.6 Significant risks were identified for Practice C following a CQC inspection on the 17 November 2022. CQC have yet to publish its findings, however the ICB held a Rapid Quality Review Meeting in December 2022 and are working with the Partners to ensure improvements in the service are achieved and safe and effective care delivered.

3.7 DHU have reported a sustained increase in complaints due to increased calls and patient volumes.

4.0 Primary Care Assurance Report

4.1 QSC were presented with its first edition of the Primary Care Assurance Quarterly Update. QSC members were very complimentary about the report and felt it offered good assurance.

4.2 Four areas of improvement were identified in the report see below: -

- Increase uptake and promotion of childhood immunisations and cervical screening
- Patients prescribed high risk medicines without the appropriate reviews taking place
- Monitoring of patient's long-term conditions and associated treatment plans not being done on a regular basis
- Promotion and development of the patient participation group

A suggestion was made that a more granular approach be considered in respect of the plans to increase the uptake of childhood immunisations as there are significant health equity concerns to be addressed.

5.0 Learning From Deaths Report

5.1 QSC were presented with the East Midlands region learning from death forum highlight report.

5.2 QSC acknowledged the need for a system wide approach rather than individual provider approach to learning from death and asked the system quality group to take this forward.

6.0 Update from Public and Patient Involvement Assurance Group (PPIAG)

6.1 QSC members were informed that the PPIAG Chair had met with Dr Sulaxni Nainani to discuss primary care services.

6.2 A discussion was held around the extreme variation of Patient Participation Group (PPG) engagement from General Practices. A strategy was agreed to work with the top 10 General Practices and support the bottom 10 to ensure levelling up of PPG engagement across LLR.

7.0 Policies/ Procedures for QSC Approval

7.1 QSC members queried if the TOR included review and approval of policies/procedures as they were an assurance committee, and this would not be usual practice. It was agreed that the Chief Nurse and Medical Director should consider the most appropriate route for Policy approvals and report back to the QSC.

7.2 The QSC members did approve the Inter-Agency Dispute and Patient Group Direction Policies as they were simply a transition from CCG policies to the ICB.

8.0 LLR System Quality Risk Register – Top Risks and Mitigations

8.1 QSC were informed of three risks which were added to the LLR system quality risk register. Firstly, workforce strikes, secondly, inadequate financial resources for CYP services and thirdly, access to primary care due to quality of providers. The risk register had not been shared with members at this meeting as it was suggested that the system quality group would review the risks monthly and the QSC quarterly. The Chair didn't feel this was adequate to be able to provide assurance to the ICB on the quality risks.

8.2 QSC members discussed the need to consider and review the format and presentation of the QSC risk register following the ICB governance development session in January 2023.

9.0 Summary of assurance from the Committee

9.1 The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Terms Reference/ Workplan	**AMBER**	The workplan and TOR are currently under review and will be completed following the ICB Governance development session to be held on the 12 January 2023.	
2. ICB Chief Nursing Officer/ Chief Medical Officer Quality Assurance Report	**AMBER**	• Strong and tested plans are in place for industrial action • CYP risk has been escalated by the Design Group for further assessment • LLR ICB are engaged with Oakham Medical Practice, Spectrum Health and Practice C – work is ongoing and CQC are sighted on progress.	Concerns have been raised about 4 areas of CYP services, listed below:- • Increased demand in Urgent & Emergency Care department and Children's Hospital • Timely assessment, management and treatment of respiratory disease • Timely access to therapy provision • Timely clinical review and management of children with SEND A deep Dive will be held on 2 February 2023 to better understand the risks and mitigations.
3. Primary Care Assurance Report	**AMBER**	• First version of the Primary Care Assurance Report for Q2 was presented to QSC. There is a gap in Assurance that the plans to improve childhood immunisation uptake are sufficiently targeted to address Health inequalities and may therefore not be effective	
4. Learning From Deaths Report	**AMBER**	• QSG tasked with coordinating the system wide approach to learning from death	
5. Update from Public and Patient Involvement Assurance Group	**AMBER**	• PPIAG will be engaging with the top 10 General Practices which have the most successful engagement record with PPGs and support the bottom 10 PPGs to level up.	
6. Policies and Procedures for QSC Approval	**GREEN**	• Both policies were approved.	

7. LLR System Quality Risk Register – Top Risks and Mitigations	**BLUE**	• 3 additional risks were added to the risk register but they were not considered in detail at the meeting • ICB to hold development session to review current governance arrangements – subsequently QSC will be able to assess its management of the LLR system quality risk register.	

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Quality and Safety Committee report for assurance.

o

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**9 February 2023**	**Paper:**	**O**
Report title:	**Assurance Report from the Audit Committee**		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes from the meeting of the Audit Committee held in December 2022. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.
2. A summary of the level of assurance provided by the Committee is detailed in paragraph 12.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The focus is on the effectiveness of the risk management and internal control processes, which includes review of the Board Assurance Framework and associated processes.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

Assurance Report from the Audit Committee

Introduction

1. This report provides a summary of the key areas of discussion and outcomes from the meeting of the Audit Committee held in December 2022. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

External and Internal Auditors

2. The **External Auditors** advised of no significant updates with regards to external audit planning. The Joint Audit Plan for the three CCGs for the period ending 30 June 2022 was provided with a final assurance update expected in April 2023. There have been no material changes to the Audit Risk Assessment as at 30 June 2022.

3. The **Internal Auditors** confirmed that all historic audit actions prior to 1 July 2022 had been closed and any actions previously relating to financial controls will be tested in the finance audit reviews for 2022/23. The following reports had been issued by the Auditors following the completion of the relevant internal audits and all reports provided a positive assurance:

    a. Review of HFMA Improving NHS Financial Sustainability Checklist
    b. ICB Head of Internal Audit Stage 1 review
    c. Risk Management Phase 1 review.

Risk Management arrangements

4. An overview was provided of the current Board Assurance Framework (BAF) and risk management arrangements in place across the ICB. Current arrangements were noted as being effective and the Committee supported the work underway to review and improve processes, recognising the need to ensure risk management arrangements continue to be dynamic and 'live'.

5. The Committee supported the need to differentiate a risk from an issue, and accurate risk descriptions being critical to enable appropriate controls and mitigations to be determined to support informed decision making. The Committee was supportive of the approach of BAF risks being assigned and overseen by each Board Committee as opposed to committees creating and managing operational risk registers, which is a matter for the executive management team.

6. The Committee welcomed the forthcoming Board development session to explore risk appetite as a Board and to develop risk management principles collectively both for the ICB and when considering system wide risks.

Business Continuity Plans

7. An assurance report on business continuity was received by the Committee demonstrating how the principles and processes have been embedded across the organisation through the development of directorate and function level business continuity plans. It was noted that these plans would be tested in February / March 2023. The Committee was assured by the actions taken, and would be considering the findings of the testing, including areas for learning, at a future meeting.

8. Further assurance on effectiveness of the controls will be sought through the internal audit review scheduled to be undertaken in quarter 4 covering Emergency Preparedness, Resilience and Response and business continuity.

Waiver of Standing Orders

9. There were no waivers of Standing Orders to be reported. It was agreed that single tender waivers would be reported in future reports.

Loss and Special Payments

10. The Committee were assured of no new losses or special payments as of 30 November 2022 with previous payments being re-classified as "claims abandoned" in line with the ICB guidance rather than classifying them as "fruitless payments".

Deep dive - Cyber Security

11. Following a detailed overview of the systems and processes in place to manage cyber security risks, the Committee felt assured in respect of the controls in place and the work undertaken to mitigate cyber security risks.

Summary of assurance from the Committee

12. The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalated where required
1. Committee governance arrangements		• N/A	N/A
2. Progress against External Audit Plan	**Green**	• Positive progress in being made.	N/A
3. Progress against Internal Audit Plan	**Green**	• Positive progress was evidenced.	N/A
4. Progress against Counter Fraud Plan		• N/A	N/A
5. Timely implementation of internal audit recommendations	**Green**	• Positive progress was evidenced.	N/A
6. Plan in place to undertake Financial sustainability audit review	**Green**	• Plan reviewed previously and assurance provided to confirm implementation of actions.	N/A
7. Effectiveness of the ICB risk management arrangements	**Amber**	• Positive progress continues to be made, the level of assurance is amber to reflect the work underway to further develop the ICB BAF.	N/A

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at meeting as item not due.

Recommendations
The LLR Integrated Care Board is asked to:

- **RECEIVE** the summary report for assurance.

P

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	9 February 2023	**Paper:**	**P**
Report title:	**Assurance Report from the Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Non-Executive Member		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Sarah Prema, Chief Strategy and Planning Officer		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the Health Equity Committee held on 20 December 2022. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed in paragraph 10.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒

7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	There is a focus on providing assurance that health inequalities are being addressed in an appropriate and systematic way.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Assurances received in relation to the health inequalities fund and available investment into work addressing health inequalities (paragraphs 8 and 9).
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however due regard is considered within reports presented to the Committee.

Assurance Report from the Health Equity Committee

Introduction

1. This report aims to provide assurance to the Board and a summary of the key areas of discussion and outcomes, aligned to the Committee's delegated authority, following the meeting of the Health Equity Committee held on 20 December 2022. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Assurance on delivery

2. The ICB approved in principle the proposal to set up an LLR Health Inequalities Unit as part of its approval in February 2022 of the LLR Health Inequalities Framework "Better Health for All".

3. The **Proposal to Launch LLR Health Inequalities Support Unit** outlined a phased approach to establishing a fully mature unit. Phase one includes the temporary recruitment of a data analyst / project manager to undertake work under the direction of a steering group. This resource will assist collaboratives and design groups in identifying priorities. A business case for recurrent funding of an appropriately sized function will be developed during 2023-24.

4. The committee supported the phased approach to the creation of an LLR Health Inequalities Support Unit (HISU). It was agreed for reviews to take place to identify where the work is adding value and the Terms of Reference for the steering group are to be developed.

5. **Assurance reporting for the Health Equity Committee** – the Committee received an update on progress to date of the creation of a local dashboard and an overview of performance against the Core20Plus5 metrics. This included a draft timetable for the development of the dashboard and the proposed reporting arrangements for the HEC.

6. MLCSU were asked to support the development and quoted £47,400. The Committee approved the recommendation not to commission MLCSU to develop a dashboard and to instead adopt the Regional Core20Plus5 dashboard as an interim measure. Challenges were highlighted in the availability and quality of data. The Committee received assurance that the dashboard will be refined as data collection improves.

7. **Health Equity Committee Focus Areas –** The Committee considered a programme of focused topics for the Health Equity Committee to approve. It was agreed that the proposed programme is to be revised to include those areas which can make the most demonstrable impact across LLR.

8. The Committee received an **Update on the health inequalities fund** including an overview of the BCF Health Inequalities Reduction Fund Investment Plan. There is a balance of circa £5m for the system to determine best use of through 23/24 and into future years. Any new proposals for health inequality schemes would need to be submitted as an investment request for prioritisation in the 23/24 planning round.

9. A concern was raised that funding into Tier 3 integrated weight management has been committed from the Health Inequalities fund. Further detail was requested as to how the funding will be utilised to specifically address Health Inequality.

Summary of assurance from the Committee

10. The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Assurance on delivery	**Amber**	• A phased approach to launching a Health Inequalities Support Unit has been approved. • Work on the dashboard is being progressed to enable assurance to be sought on implementation of the Strategy. The dashboard is to be refined as data collection improves. • A programme of focused topics for consideration by the Committee is being developed. • Further detail has been requested to ensure appropriate allocation from the Health Inequalities fund.	N/A

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**9 February 2023**	**Paper:**	**Q**
Report title:	**Assurance Report from the inaugural Equality, Diversity and Inclusion Advisory Group**		
Presented by:	David Sissling, Chair of the Integrated Care Board		
Report author:	Alice McGee, Chief People Officer		
Sponsor:	Alice McGee, Chief People Officer		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report and note the proposal to share the outcomes regularly with the Health and Well Being Partnership

Purpose and summary of the report:

1. This report provides a summary of the inaugural Equality, Diversity and Inclusion Advisory Committee. The Board is asked to note the progress shared and the proposal to use the discussions from the advisory committee to advise the Board and the Health and Well Being Partnership on the progress and principles of the LLR approach to equality, diversity and inclusion.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☐
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☐

Conflicts of interest screening		Summary of conflicts *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The Board Assurance Framework is being reviewed and a key risk to be articulated is the staff satisfaction and retention challenges for the NHS and LLR. The inclusion agenda supports staff to feel a sense of belonging and inclusivity therefore the agenda is key to our people risks and development
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		The advisory committee will be considering the impacts of the Equality Delivery System 2022 and the work undertaken to delivery this duty

Assurance Report from the Equality, Diversity and Inclusion Advisory Group

Introduction

1. The EDI Advisory Group has been set up to create a continued focus on the approach LLR takes to EDI, for its staff and our communities. The EDI advisory committee will be focussed on learning, developing and testing thinking around the equality, diversity and inclusion agenda

2. The delivery of the People Plan, of which EDI is a key component, remains the responsibility of the People and Culture Board however the Advisory Committee will be responsible for looking at our health and social care priorities from al lens of our staff and our diverse population to ensure we are considering factors relating to diversity in our decision making

Membership and Approach

3. The Advisory Committee will not be a formal decision-making committee. The Group format and purpose was to learn together in an open way, challenge issues in a respectful manner and collaborating to pool expertise to ensure progress was made.

4. The membership will have Non-Executive Directors, Directors, Staff Network representatives and EDI experts from across health, social care and the wider public sector. Invites will be shared with colleagues in the coming weeks

5. The advisory group will meet quarterly to review progress and learn together. It is anticipated that the outputs of the advisory committee will form agenda items for both the NHS Integrated Care Board and the Health and Well Being Partnership

Inaugural Meeting

6. The first meeting explored two key topics to commence our collective learning:
    a. Understanding of the Inclusive Decision Making Framework
    b. Understanding of the current programmes of work around EDI for our staff

7. Both agenda items allowed the Advisory Group to have a collective understanding of the programmes of work, to understand the intended impact and to share learning from the programmes. The advisory committee commended the work to date and recognised the national and regional profile of our programme, including winning awards at the recent regional equality awards

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report and note the proposal to share the outcomes regularly with the Health and Well Being Partnership